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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

REGINA

SASK.

VOLUME NUMBER:

20

DATE:

JANUARY 25 1962

V. 20 Briefs 96 - 107
V. 21 Briefs 108 - 111
V. 22. Briefs 112



V. 23 Briefs 113 - 118

OFFICIAL REPORTERS
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ROYAL COMMISSION ON HEALTH SERVICES

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January 25th, 1961

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University of Saskatchewan

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COMMISSION MEMBERS:

4748 CHIEF JUSTICE EMERSON OF
Saskatchewan

4771 MISS ALICE GIRARD, R.N.
St. Peter's Hospital

4784 DR. DAVID M. BALZAN
The Canadian Council on Alcoholism

4791 PROF. J.O. FIRESTONE
The Regina Grey Nuns' Hospital

MR. M. WALLACE MCUTCHEON, Q.C.

DR. C.L. STRACHAN

DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. N. LAFRANCE



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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held at Regina, Saskatchewan,
January 25th, 1962

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT H. HALL - Chairman

MISS ALICE GIRARD, R.N.

DR. DAVID M. BALTZAN

PROF. O.J. FIRESTONE

MR. M. WALLACE McCUTCHEON, Q.C.

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DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. N. LAFRANCE



PROCEEDINGS OF THE HEARING

held at Regina, Saskatchewan,
November 19, 1954

COMMISSION MEMBERS:

MR. JUSTICE GILBERT - Chairman

MRS. ALICE GILBERT, R.N.

MR. M. WALLACE MCGILLIVRAY, Q.C.

DR. C.L. STROGAN

DR. ARTHUR F. VAN WART

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. VINCENT J. JONES

DIRECTOR OF RESEARCH:

MR. N. LAFRANCE



1 Regina, Saskatchewan
2 Thursday,
3 January 25th, 1962

4 ---ON RESUMING AT NINE O'CLOCK A.M.

5 THE CHAIRMAN: We are ready to proceed this
6 morning with the submission of the Saskatchewan Psychiatric
7 Nurses Association.

8 SUBMISSION

9 of the

10 SASKATCHEWAN PSYCHIATRIC NURSES ASSOCIATION

11 APPEARANCES:

12 MR. M. SCHREDER

13 MRS. F. SONNERGREN

14 MR. D. SANE

15 ---EXHIBIT NO. 97: "Brief of the Saskatchewan
16 Psychiatric Nurses Association."

17 MR. SCHREDER: Mr. Chairman, Members of the
18 Commission, with your permission I would like first of all
19 to introduce the Members of the group who are seated here:
20 Mrs. Fay Sonnergren, who is Chairman of the Saskatchewan
21 Psychiatric Nurses Association and Senior Instructress at
22 the School of Psychiatric Nursing at Weyburn; Mr. Dean
23 Sane who is a member of the Saskatchewan Provincial Council
24 and an instructor at the School of Psychiatric Nursing at
25 Moose Jaw. I am M. C. Schreder, Chairman of the Committee
26 on Briefs and Supervisor of Education at the school at
27 Weyburn.

28 I think in proceeding I would like to say a
29 few words of introduction as to our reasons for submitting
30 our Brief to the Royal Commission. We appreciate the

January 25th, 1962

---ON RESUMING AT NINE O'CLOCK A.M.

THE CHAIRMAN: We are ready to proceed this morning with the submission of the Saskatchewan Psychiatric Nurses Association.

SUBMISSION

SASKATCHEWAN PSYCHIATRIC NURSES ASSOCIATION

MR. M. SCHNEIDER

MR. D. SAUB

---EXHIBIT NO. 97: List of the Saskatchewan

MR. SCHNEIDER: Mr. Chairman, Members of the Commission, with your permission I would like first of all to introduce the Members of the group who are seated here: Mrs. Ray Sommergren, who is Chairman of the Saskatchewan Psychiatric Nurses Association and Senior Instructor at the School of Psychiatric Nursing at Weyburn; Mr. Dean Kane who is a member of the Saskatchewan Provincial Council and an instructor at the School of Psychiatric Nursing at Moose Jaw. I am M. C. Schneider, Chairman of the Committee on Briefs and Supervisor of Education at the school at Weyburn.

I think in proceeding I would like to say a

our brief to the Royal Commission. We appreciate the



1 opportunity to have audience before you, and we hope that
2 our small contribution will perhaps do something in bring-
3 ing to the attention of the Royal Commission the problems
4 as we see them in regard to mental health.

5 We have submitted this Brief to the Royal
6 Commission because we believe there is a need for improve-
7 ment in the services offered for Mental Health across the
8 Nation. Since psychiatric disorders fill 40% or more of the
9 total hospital beds, the majority of which are housed in
10 large, outmoded mental hospitals and since only a small
11 percentage of the monies spent on Health Services are al-
12 lotted to Mental Health we believe the problem warrants
13 National concern.

14 When I say "a small percentage of monies
15 spent on Health Services", we are thinking primarily of the
16 costs per bed. This is the kind of information we have,
17 and I think it came out last evening that to maintain a
18 patient at a mental hospital costs approximately \$5.00 a
19 day, whereas, of course, in the general hospitals, the cost
20 runs around \$20.00 and upwards.

21 We have dealt primarily with the situation
22 as it exists in this province, because this, of course, is
23 what we are most familiar with. While we are faced with
24 the problem of large outmoded hospitals we are in the for-
25 tunate position of having the best ratio of trained staff
26 of any Province in the Dominion. This is probably because
27 of the training program available in psychiatric Nursing
28 in Saskatchewan. We have appended an outline of the
29 curriculum for psychiatric nurses to this Brief for study
30 by the Commission. According to W.H.O. report number 73



1 opportunity to have audience before you, and we hope that
2 our small contribution will perhaps be something in that
3 line. We are not at all sure of the results of the
4 study, but we are sure that it is a very important
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101 When I say "a small percentage of monies
102 spent on health services", we are thinking primarily of that
103 costs per bed. This is the kind of information we have,
104 and I think it came out last evening that to maintain a
105 patient in a mental hospital costs approximately \$5.00 a
106 day, whereas of course, in the general hospitals, the cost
107 runs around \$20.00 and upwards.
108 We have dealt primarily with the situation
109 as it exists in this province, because this, of course, is
110 what we are most familiar with. While we are faced with
111 the problem of how to improve the situation in the other
112 provinces position of having the best ratio of trained staff
113 of any Province in the Dominion. This is probably because
114 of the training program available in psychiatric nursing
115 in Saskatchewan. We have appended an outline of the
116 curriculum for psychiatric nurses to this Brief for study
117 by the Commission. According to W.H.O. report number 73



1 published in September 1953; countries who have adopted the
2 system of comprehensive training courses for psychiatric
3 nurses organized within the psychiatric hospitals with a
4 Nationally recognized examination and a National register
5 for Psychiatric Nurses, have been more successful in obtain-
6 ing the staff they need for their hospitals. We believe
7 the program for the training of psychiatric nurses which
8 we have in this Provinces is a good one and we would like
9 to see it extended across the Nation with the institution
10 of a National Register for Psychiatric Nurses. This is in
11 fact one of the recommendations included in our Brief.

12 While we maintain that we believe the pro-
13 gram we have in this Province is a good one, we constantly
14 give it study and improve on it to meet the needs as we see
15 them.

16 We also believe that better facilities for
17 the mentally ill would attract more people into entering
18 a profession for their care. For this reason we strongly
19 support the Saskatchewan plan for a system of community
20 regional hospitals. We include this also in our recommen-
21 dations.

22 Just a few words about the content of the
23 Brief. I don't intend to read the Brief in detail, but to
24 indicate some of the areas we have dealt with in the Brief
25 to the Commission. One thing we outline, a little bit of
26 the history and story of the Saskatchewan Psychiatric Nurses
27 Association which, as you know, from the Brief was estab-
28 lished by legislation in 1948, and we now have an active
29 membership of over six hundred. We have our objectives and,
30 of course, we have our Code of Ethics.



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of course, we have our Code of Ethics.



1 Secondly, we try to indicate as we see the
2 problem in mental health and we indicate with a few statis-
3 tics. I think it is generally known and accepted that the
4 people suffering from psychiatric disorders today constitute
5 40% or more of the population in the hospitals. Across
6 the nation 74% of those people who are in mental hospitals
7 have been there for at least two years or more, and we feel
8 this is a fact which should warrant national concern.

9 We indicate what we believe is the trend
10 in mental illness; that is, the trend in treatment and
11 housing, and we believe that because of the trends which
12 are entering into this field that we should examine critical-
13 ly the facilities we have to offer. We believe this is
14 true not only in this province, but again across Canada.

15 In talking about the trend, we talk about
16 what we think the size of a hospital should be and what we
17 believe the staffing of this hospital should be, what we
18 feel needs to be done in educating the public as to the
19 needs of the mentally ill, and the needs in regard to their
20 care and treatment.

21 We are not too expert in money matters. We
22 haven't been able to say too much about what this would
23 cost, but again we have drawn some information from studies
24 by the World Health Organization wherein they state that
25 the optimum capacity economy-wise for mental hospitals
26 seems to be between 250 to 400 beds. Over this the costs
27 seem to rise, probably because of the wastage and the
28 mechanization which has to go on in a large institution.

29 We also deal with the present situation in
30 Saskatchewan. As I mentioned earlier, although we do



Secondly, we try to indicate as we see

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mechanization which has to go on in a large institution.

We also deal with the present situation in

Saskatchewan. As I mentioned earlier, although we do



1 believe we are rather fortunate in this Province that we
2 have a goodly number of trained people dedicated to the
3 care of the mentally ill, we still believe much more could
4 be done in this Province, and certainly on a national level.

5 We include only a few recommendations. Our
6 intent in this Brief was to try and present a brief, concise
7 picture as we see it of what we believe could be done to
8 perhaps alleviate the conditions which presently exist.
9 With your permission, I would like to quickly run over the
10 recommendations we have made to you.

11 The first one is that a common system of
12 training psychiatric nurses, similar to the Saskatchewan
13 program, be organized on a national basis with a nationally
14 recognized examination and a national register for psy-
15 chiatric nurses. We are fully aware that there is a shor-
16 tage of nurses in all fields, and we firmly believe that
17 with better facilities and more recognition, particularly
18 national recognition in this field of nursing that we
19 would get many more well-qualified and well-motivated
20 people into the field, and they could have freedom of move-
21 ment across the Nation, and so on.

22 Secondly, I have indicated before that our
23 Association supports the Saskatchewan plan; in other words,
24 we recommend a system of community mental hospitals be
25 instituted across Canada. These could be strategically
26 placed near general hospitals in order to share facilities
27 such as heating, laundry, stores etcetera. Its administra-
28 tion, finances and staff should be entirely independent.

29 Thirdly, a system of providing public infor-
30 mation and mental health education be devised. We make a



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tion, finances and staff should be entirely independent.
Thirdly, a system of providing public infor-
mation and mental health education be devised. We make a



1 few suggestions as to how we feel this could be done. We
2 think there still is a great need for informing the public
3 about mental health, mental illness and the help that can
4 be given in this field.

5 Fourthly, a national health administration
6 to include among its administrative officers psychiatric
7 nurses with responsibility for the overall planning of
8 nursing service and nursing education in mental hospitals
9 and other mental programs. I think perhaps our reason for
10 this recommendation can be deduced from the Brief. We
11 believe that the psychiatric nurse is the key figure in the
12 social milieu we plan for our patients, and therefore should
13 have a part in planning nursing services and education in
14 this field, and particularly in the mental hospitals.

15 Finally, which I was sort of led to believe
16 last night that most organizations have put to you, is that
17 bursaries or fellowships be provided for psychiatric nurses
18 to prepare them for advanced positions in psychiatric nursing
19 advanced positions in leadership, advanced positions in
20 the schools of psychiatric nursing in the psychiatric nurs-
21 ing service, and this sort of thing.

22 Once again I would like on behalf of the
23 Saskatchewan Psychiatric Nurses Association to thank you
24 very much for this opportunity of having audience with you,
25 and we would like to urge the Commission to give serious
26 study to the problems of mental health as we have posed
27 them and to the recommendations which we have herein made.

28 I would like to stop there, and we would be
29 willing to try to answer any questions that the Commission
30 would like to put before our small group here.



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8 this recommendation can be deduced from the fact. We

9 mental illness we plan for our patients, and therefore about

10 have a part in planning nursing services and education in

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13 least might that most organizations have got to have, as that

14 personnel or fellowship be provided for by mental hospitals

15 to prepare them for advanced positions in psychiatric work

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17 the schools of psychiatry, training in the psychiatric work

18 the service, and this sort of thing.

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20 Psychiatric Nurses Association to thank you

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22 and we would like to urge the Commission to give serious

23 study to the problems of mental health as we have posed

24 I would like to stop there, and we would be

25 willing to try to answer any questions that the Commission



1 THE CHAIRMAN: Thank you very much, Mr.
2 Schreder. I might break a rule I have had about commenting
3 on Briefs, and make an exception in your case: I am impres-
4 sed with the fact that you come as a group and you ask
5 nothing for yourselves, but only for the people for whom
6 you work and with whom you work, and you have dealt with
7 the subject in terms of general principles and ideas which
8 you would like to see put into practice for the benefit of
9 the patient.

10 Just on this one subject of bursaries: Are
11 there any available now?

12 MR. SCHREDER: Mr. Chairman, in this Province
13 there are bursaries made available through the Psychiatric
14 Services Branch for Registered Psychiatric Nurses to
15 attend the School of Nursing at the University of Saskat-
16 chewan. There are two programs open to psychiatric nurses:
17 A diploma course in teaching and supervision, and also a
18 diploma course in administration. The bursaries are supplied
19 through the Psychiatric Division of the Department of
20 Public Health.

21 THE CHAIRMAN: Are they adequate? Is this
22 a recommendation that you think for the overall picture it
23 should be developed further? Is that what you have in
24 mind?

25 MR. SCHREDER: Yes, this is our belief, that
26 they should be developed further. Of course, associations,
27 I think, always believe that the bursaries are not adequate.
28 We are not too discontent in this Province insofar as
29 bursaries are concerned, but we are speaking here again
30 more or less from a national level. I believe this is the



11: Thank you very much, Mr.

12: While I have had about enough

13: you work and with whom you work, and you have dealt with

14: the subject in terms of general principles and ideas which

15: you would like to see put into practice for the benefit of

16: Just on this one subject of nurses:

17: MR. CHAIRMAN: Mr. Chairman, in this Province

18: there are positions made available through the Psychiatric

19: Nurses Branch for registered Psychiatric Nurses to

20: attend the School of Nursing at the University of Toronto

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23: diploma course in administration. The graduates are supplied

24: through the Psychiatric Division of the Department of

25: Public Health.

26: THE CHAIRMAN: Are they accepted? Is this

27: a recommendation that you think for the benefit of the

28: should be developed further? Is that what you have in

29: mind?

30: MR. CHAIRMAN: Yes, this is our belief

31: they should be developed further. OK, thank you.

32: I think, always believe that the nurses are not doing

33: we are not too dissatisfied in this Province as far as



1 only province where bursaries are available to psychiatric
2 nurses.

3 THE CHAIRMAN: It is gratifying to hear
4 such progress has been made.

5 COMMISSIONER GIRARD: Mr. Schreder, I don't
6 know whether I recall correctly, but you seem to say that
7 you have enough or have an abundance of psychiatric nurses,
8 and I think there was a Brief this week which mentioned a
9 shortage of 1100. I may be wrong -- we have had an awful
10 lot of briefs -- and my memory may not be what it should
11 be.

12 MR. SCHREDER: Maybe I didn't make myself
13 clear. I didn't mean to give you the impression we feel
14 we have enough psychiatric nurses. We believe as an
15 Association that we have more in this Province within the
16 mental health services than they have in other Provinces,
17 and in this we say we are fortunate. This certainly does
18 not mean we have enough. If we look at the statistics, we
19 have have in the hospitals, in psychiatric wards in the
20 Provinces, about 4400 in-patients. To care for them we
21 have approximately 600 registered psychiatric nurses. So,
22 by quick division, this makes about one psychiatric nurse
23 to seventy patients.

24 THE CHAIRMAN: And they are nursing on a
25 twenty-four-hour basis -- is it an eight-hour shift?

26 MR. SCHREDER: That is right.

27 THE CHAIRMAN: Three hundred and sixty-five
28 days a year?

29 MR. SCHREDER: That is right.

30 COMMISSIONER GIRARD: Mr. Schreder, on page

4 such progress has been made.

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18 have have in the hospitals, in psychiatric wards in the

19 Province, about 400 in-patients. To care for them we

20 have approximately 600 registered psychiatric nurses. So,

21 by quick division, this makes about one psychiatric nurse

22 to every patient.

23 THE CHAIRMAN: And they are nursing on a

24 twenty-four-hour basis -- is it an eight-hour shift?

25 MR. SCHNEIDER: That is right.

26 THE CHAIRMAN: Three hundred and sixty-five

27 MR. SCHNEIDER: That is right.



1 two, and again in your recommendations -- on page two it is
2 in the objectives, number 8: The objective is to promote
3 professional psychiatric nursing throughout the Nation.
4 This method has been successful in Saskatchewan. From your
5 Brief, I believe you have had good results, but what is
6 successful in one Province may not be as successful in
7 another Provinces. Your objective is to have psychiatric
8 nurses trained in this manner throughout the Nation. Do
9 you think some Provinces may have other views on this?
10 Do you advocate this as being the best way to deal with the
11 problem?

12 MR. SCHREDER: As we see it, yes, Miss
13 Girard. Again, I might mention I believe Saskatchewan
14 pioneered this profession; that is, as being a separate
15 profession in mental hospitals with people specifically
16 trained in the care of the mentally ill. This objective
17 probably, I would agree, sounds like a pretty high one. I
18 might say, though, that since ---

19 THE CHAIRMAN: There is nothing necessarily
20 wrong with a high objective.

21 MR. SCHREDER: No, but I would like to
22 mention although it may be true that some Provinces don't
23 adhere to this at the moment, since the Saskatchewan
24 Association was organized they have organized similar --
25 and we don't feel they are quite up to our level as yet ---
26 in British Columbia, Alberta and Manitoba. So, it has
27 spread somewhat since the organization of the Association
28 in Saskatchewan.

29 COMMISSIONER GIRARD: On page seven, para-
30 graph three you talk about a system of providing public



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...I believe you have had good results. But what

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...you think some provinces may have other views on this?

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...in Saskatchewan.

COMMISSIONER LINDARD: On page seven, para-

...and three you talk about a system of providing public



1 information and mental health education being devised, and
2 you go on to say that perhaps the first activity should be
3 the provision of sufficient psychiatric staff, including
4 nurses, for the existing hospitals to enable the staff to
5 spend about one-third of their time on community activities
6 such as the spreading of information to the public: How
7 would you go about this, Mr. Schreder? You advocate taking
8 one-third of the time of the staff to do the public infor-
9 mation work?

10 MR. SCHREDER: Well, again, the Association
11 believes that this recommendation follows the former one
12 of a system of community hospitals whereby the care of the
13 mentally ill would go back into the community. The third
14 recommendation, as we see it, would automatically happen if
15 the system of community hospitals happened, because you
16 would be dealing very much with the family; the families
17 would be brought into the hospital and there would be much
18 closer liasion. We could be wrong, but we believe this
19 could probably automatically happen if a system of community
20 mental hospitals were instituted, because there would be
21 much closer liasion with the community. This is one of the
22 ideas behind the system -- to bring the community closer
23 to the patient and the patient closer to the community.

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21 much closer liaison with the community. This is one of the
22 ideas behind the system -- to bring the community closer
23 to the patient and the patient closer to the community.



mcH/SS

1 THE CHAIRMAN: And now, in connection with
2 the proposed educational program you say that you have used
3 a system that is working well in Saskatchewan and you recom-
4 mend it for other parts of Canada. Does that necessarily
5 involve that it must be identical in other places?

6 MRS. SONNERGREN: I think our basic idea
7 here is that the nurse who is going to give the direct care to
8 the mentally ill should be prepared on a professional
9 basis in that area.

10 THE CHAIRMAN: The area in which she is going
11 to serve?

12 MRS. SONNERGREN: Yes, and adequate prepara-
13 tion in that area, that is the point, as far as education
14 is concerned, very well prepared in that area. As we
15 brought out in our Brief, the nurse in the social milieu
16 is the one who is structuring it and the way the nurse
17 operates within that field, in that milieu, determines what
18 the milieu will be. Therefore, you need professionally
19 prepared people in that milieu and we do not feel that sub-
20 professional people can do an adequate job in that area.
21 These people have been used when they did not have anything
22 better, but we feel they must be well-prepared.

23 THE CHAIRMAN: Mr. Sane, anything to add?

24 MR. SANE: Still on the same question, basi-
25 cally I feel that this program basically should be identical
26 but, of course, it has to go with the needs in each Prov-
27 ince and each situation. Basically the fundamentals are
28 all the same, the principles are the same.

29 COMMISSIONER STRACHAN: What number of male
30 nurses have you?



1 MR. SCHREDER: I'm not prepared to give you
2 an accurate figure.

3 COMMISSIONER STRACHAN: Well, just generally?

4 MR. SCHREDER: I would think that it is just
5 about equal, about fifty-fifty. That is, in the total num-
6 ber of registered psychiatric nurses that we have of some
7 six hundred, we would have approximately three hundred of
8 each sex.

9 COMMISSIONER STRACHAN: How does the turn-
10 over compare?

11 MR. SCHREDER: The turn-over is greater, of
12 course, in the women through marriage and so forth.

13 COMMISSIONER STRACHAN: What is the length
14 of training?

15 MR. SCHREDER: Three years and I think I
16 would like Mrs. Sonnergren to tell you a bit about the
17 three years and what it constitutes.

18 MRS. SONNERGREN: Well, as we have pointed
19 out that we have our academic program which is carried on
20 with our experience, correlated with it. We try to have
21 our students progress from the first, second and third years
22 into the senior year, and this is actually a year of broad
23 looking at their field. This is why we recommend a seminar,
24 we think it is in the third year that they have to have a
25 chance to look very broadly at, not only their own work,
26 but others in the field and they have an experience of group
27 experience in this seminar of other people who prepare them
28 for their work. This is actually a finishing touch later
29 to give them not only theoretical knowledge, but through
30 their experience and their theoretical knowledge to make



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for their work. This is actually a fascinating touch later

to give them not only theoretical knowledge, but through

their experience and their theoretical knowledge to make



1 them people who see this, who understand other people. It
2 is very extensive preparation in this area.

3 COMMISSIONER VAN WART: What is the prelimi-
4 nary educational standard?

5 MRS. SONNERGREN: The minimum of grade 11,
6 this is Saskatchewan and it might mean in Manitoba what
7 they call grade 12, that would be the minimum. Of course,
8 some of the things we have laid out in our curriculum is
9 not that we think it is exactly the way it should be. We
10 have tried to be realistic and stay in line with the facili-
11 ties. We think if we had reasonable mental hospitals, as
12 we hope to have, we would no doubt change our recommenda-
13 tions for curriculum.

14 COMMISSIONER BALTZAN: It was said earlier
15 that you required more nurses although you actually have
16 more nurses compared with other areas. Have you much
17 trouble in the recruitment, in attracting students?

18 MR. SANE: In the past few years particular-
19 ly the last two or three years with the economic situation
20 as it is, we have had more applications, I believe, than
21 we could possibly handle. As a result, I think we can
22 select much better. We have a much better selection pro-
23 gram now for the first year student and deciding who is
24 going to make a good psychiatric nurse and who is not. A
25 lot of our personnel in the hospitals do a lot of research
26 in attempting to establish aptitude programs whereby they
27 can give this type of individual a test to decide if this
28 person, he or she, will be able to function with the
29 psychiatric patient.

30 COMMISSIONER BALTZAN: It was said earlier



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psychiatric patient.

COMMISSIONER BALDWIN: It was said earlier



1 that the ratio of male to female is almost equal right now.
2 Certainly this is different than in former years, or is it?

3 MR. SCHREDER: Insofar as the mental hospitals
4 are concerned, I think the ratio has always been about
5 equal. As a matter of fact, I think perhaps a few years
6 ago the men used to hold the majority. Now it seems that
7 we have more female applicants than we do male by quite a
8 bit. However, as was brought out by the question over here,
9 the male applicant entering psychiatric nursing who success-
10 fully attains it seems to stay in the profession better and,
11 therefore, the division seems to be about equal. That is
12 in qualified registered psychiatric nurses. You will find
13 that in your student group you have more women than men,
14 but in the overall picture it runs about equal.

15 COMMISSIONER BALTZAN: About how far back
16 can you record this new trend of attracting more female
17 students? The last five or ten years?

18 MR. SCHREDER: Well, actually in my time in
19 the field it has always been this way, there have been more
20 female students than male. Even when I was in classes we
21 were a class of ten men and sixteen girls, so in my field
22 it has always been this way.

23 COMMISSIONER BALTZAN: Only the males re-
24 main longer at it?

25 MR. SCHREDER: Yes, they seem to be more
26 stable. Mind you, I think this is the right thing in our
27 society.

28 THE CHAIRMAN: Mrs. Sonnergren, your system
29 now, is it based on the two large hospitals, particularly
30 the large hospital at Weyburn with training psychiatric



10 the large hospital at Weidman with training psychologists
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12 THE CHAIRMAN: Mrs. Sommerger, your system
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14 MR. SCHLESINGER: Yes, they seem to be none
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21 MR. SCHLESINGER: Well, actually in my time in
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24 COMMISSIONER BARRY: About how far back



1 nurses?

2 MRS. SONNERGREN: Well, yes.

3 THE CHAIRMAN: Now, you say for the future
4 the elimination of the large hospital and a considerable
5 number of smaller units throughout the province. How will
6 that affect your educational program when you change from
7 the large unit to the smaller units?

8 MRS. SONNERGREN: It will, I think, affect
9 it this way: In the preparation for giving care to the
10 medical and surgical nursing, for instance, now because
11 of the type of facility we have we do look after patients
12 that have surgical conditions at the present time in Wey-
13 burn. I do not know about other places, but we send them for
14 the operation to the general hospital and in most cases
15 they return almost immediately. This does not make a
16 difference if you had great facilities for care but it may
17 be we only have enough that we could observe. This is a
18 very, very important part of psychiatric nursing because
19 whereas you can depend on most people to tell where their
20 troubles are in a physical sense, you cannot with our
21 patients. Patients sometimes go around even with a broken
22 leg and it is the nurse who notices there is a broken leg.
23 This seems almost unbelievable but it is up to the nurses
24 and we always will have to have whatever the basic minimum
25 will be to understand these things. This might be some
26 change. Then, we might also be able to improve the psy-
27 chiatric part, because we would have less of one type
28 training and get more of another. You see, money is in-
29 volved.

30 THE CHAIRMAN: Could you see nurses rotating



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whereas you can depend on most people to tell where their
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1 through the area regional units and

2 experience?

3 MRS. SONNERGREN: Possibly, depending on
4 whether it would warrant sending them because here again
5 money is involved every time and some times you feel you
6 can put it off, even a good purpose, because it costs
7 money.

8 THE CHAIRMAN: I am talking about in your
9 own system for psychiatric students.

10 MRS. SONNERGREN: It would depend on whether
11 the experience would be valuable; if something could be
12 gained, we would do it.

13 THE CHAIRMAN: That is something you have
14 to face for the future if you get a new system of housing.

15 MRS. SONNERGREN: Oh, yes.

16 THE CHAIRMAN: Thank you very much. As I
17 said, this Brief covers the general proposition and this
18 is what we were particularly interested in. We are grate-
19 ful to you for your assistance.

20 MR. SCHREDER: Thank you again on behalf
21 of the Association for this audience.

22 THE CHAIRMAN: The next submission is from
23 the Saskatchewan Psychiatric Association.

24 THE SECRETARY: Exhibit Number 98.

25 ---EXHIBIT NO. 98: Submission of Saskatchewan
26 Psychiatric Association.

27
28 SUBMISSION OF
29 SASKATCHEWAN PSYCHIATRIC ASSOCIATION

30



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Submission of Saskatchewan

---EXHIBIT No. 98:



APPEARANCES:

1 DR. F. COBURN

2 DR. F. S. LAWSON

3 DR. JOHN A. McLURG

4

5 DR. COBURN: First, thank you on behalf of
6 the Association for the opportunity of presenting this
7 submission.

8

9 Our Brief is made up of several parts, the
10 patients with whom we are dealing may need a
11 summary and recommendations and preamble which sets forth

12 our general position. There is an appendix "The Saskatchewan

13 Plan" and a bibliography of some thirty-one items. It is

14 my intention simply to read the preamble and then the

15 recommendations and summary.

16

P R E A M B L E

17

18 Since the establishment of the Province of
19 Saskatchewan, with the exception of the past few years,

20 the policy implicit in the treatment of the mentally ill

21 has been the one common to most European and North American

22 jurisdictions, namely, to remove the patient from the com-

23 munity and to provide low cost custodial care. This policy

24 is no longer acceptable either to the community or to the

25 medical profession. Given proper conditions, most of the

26 mentally ill can be briefly and intensively treated and

27 safely returned to their homes (9, 10, 11, 13, 20, 21, 27,

28 28), thus relieving the human suffering of the patient and

29 the financial loss to the society in the form of lost earn-

30 ings, lost taxes, social aid to dependents and the cost of

prolonged hospital care.

31

32 Mental disorder is our major health problem.

33 Seventy-five thousand hospital beds in Canada are exclusive-

ly devoted to it, constituting almost half of the total



APPENDICES:

TORONTO, ONTARIO

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Since the establishment of the province of

medical profession. Given proper conditions mentally ill can be properly and humanely treated and safely returned to their homes (1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100). The financial loss to the society in the form of lost earnings, lost taxes, social aid to dependents and the cost of prolonged hospital care.

Mental illness is our major health problem. Seventy-five thousand hospital beds in Canada are exclusively

devoted to it constituting almost half of the total



1 number of hospital beds. These beds are of course for the
2 major mental illnesses. As to the prevalence of the neuroses,
3 it has been estimated that 10 to 60% of the general prac-
4 titioners' patients suffer from illnesses based primarily
5 on disturbances of an emotional sort, often with consequent
6 disturbances of body function. The variability in these
7 estimates is due to variations in the criteria used. Those
8 patients with conspicuous bodily complaints may receive an
9 "organic" diagnosis though emotional factors play a large
10 part in the disturbance. A conservative estimate is that
11 33% of the population suffer from emotional disorders to
12 the extent that they seek advice or treatment annually,
13 though not all of these, as previously observed, will re-
14 ceive a definite psychiatric label. Thus, probably one-
15 quarter to one-third of general hospital beds are being
16 used by patients whose trouble is essentially of emotional
17 origin. In addition to the psychotic and neurotic mentally
18 ill, it is reliably estimated that 3% of our population are
19 mentally retarded.

20 The shift in professional thinking and prac-
21 tice from a therapeutic pessimism and custodial care to
22 intensive brief treatment and rapid return to community care
23 reveals costly deficiencies in present programmes.

24 As outlined below, the daily expenditures for
25 patient care, the staff-patient ratios, the professional
26 salaries and the difficulties in recruitment of personnel
27 all reduce the effectiveness of the application of present-
28 ly known techniques to the detriment of the patient and,
29 ultimately, a greater cost to the community. In addition
30 to these handicaps to our present programme, other facili-



2 major mental illnesses. As to the prevalence of the mental
3 it has been estimated that 10 to 15% of the general population
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8 patients with conspicuous bodily complaints may receive no
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10 part in the disturbance. A conservative estimate is that
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1 ties are vitally needed. Such facilities include the
2 organization of domiciliary visiting by qualified psychia-
3 tric social workers and, if necessary, psychiatrists before
4 admission is suggested. Thus many patients can be seen
5 through their illnesses at home and where admission is
6 eventually advisable, valuable information will have been
7 obtained regarding the family situation which may aid in
8 explaining the breakdown, assist in treatment and lead to
9 realistic post-discharge planning.

10 Out-patient services are woefully inadequate,
11 forcing patients to take treatment in an institution al-
12 though, with better provisions, it could be done more
13 effectively in the community and at a lower cost. The
14 desocialization which occurs in our huge, antiquated, iso-
15 lated mental hospitals adds to the patient's difficulties
16 and hinders rather than facilitates his recovery.

17 Adequate follow-up facilities for our dis-
18 charged patients do not exist. Many patients, particularly
19 those from that backlog of the chronically psychotic, which
20 are our legacy from the era of custodial treatment which we
21 hope is now past, need help in re-establishing themselves
22 in the community from which they were rejected five to 40
23 years ago. Employment placement services and the use of
24 social case workers under psychiatric supervision would pay
25 dividends both in human usefulness and in financial returns.
26 "Half-way houses" or hostel accommodations are required
27 for the rehabilitation of those without families or whose
28 families have been lost by that tragically long hospital stay
29 which we now feel has been almost entirely unnecessary.
30 Many of our older patients could be discharged to their



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5 through their illness at times and where admission is
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1 homes if housekeeping helpers, social service and nursing
2 follow-up, supplemented by occasional psychiatric help and
3 even more occasional brief re-admissions to a community
4 hospital, were available. (7, 8). Nursing homes for
5 elderly confused patients with or without physical disease
6 are necessary and would meet, at lower than general hospital
7 cost, the needs of those who cannot be maintained in the
8 community.

ag/ss

9 SUMMARY

- 10 1. Treatment of the mentally ill is far below the stan-
11 dards set for the physically ill.
- 12 2. Per diem rates in Saskatchewan Hospitals are one-
13 quarter the rates in general hospitals.
- 14 3. Support of the mentally ill is excluded from Dominion-
15 Provincial hospital schemes, most prepaid insurance
16 plans and the Saskatchewan Medical Care Insurance
17 Act.
- 18 4. Staff ratios in mental hospitals are approximately
19 one-half of what would be needed for adequate care.
- 20 5. The psychiatrist today is the poorest paid of medical
21 specialists. This leads to difficulties of recruit-
22 ment.
- 23 6. Psychiatric services are defective in not providing
24 continuity of care in or near the patient's community.
25 Lacking are local hospital facilities, outpatient
26 facilities, hostels, nursing homes and domiciliary
27 services.
- 28 7. Medical education and L. M. C. C. examination exc-
29 lusion reduce the importance of Psychiatry to the
30 student.



1	Introduction	1
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3	The Role of the Psychiatrist	3
4	Diagnosis and Treatment	4
5	Prognosis and Follow-up	5
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27	Chapter XVII	27
28	Chapter XVIII	28
29	Chapter XIX	29
30	Chapter XX	30



1 8. Psychiatric research is starved for money, bedevilled
2 by project granting and hence without adequate num-
3 bers of workers.

4 THE CHAIRMAN: Thank you very much, Dr.
5 Coburn. Is there anything further that you wish to add,
6 Dr. Lawson?

7 DR. LAWSON: I don't think so, sir, at this
8 moment.

9 THE CHAIRMAN: Dr. McLurg?

10 DR. McLURG: No, sir, I think most of the
11 information is in the Brief.

12 THE CHAIRMAN: There is something that I
13 would like you, Dr. Coburn, if you would comment upon, on
14 page 3 you say: "As outlined below, the daily expenditures
15 for patients' care, the staff-patient ratios, the profes-
16 sional salaries and the difficulties in recruitment of
17 personnel all reduce the effectiveness of the application
18 of presently known techniques to the detriment of the
19 patient ---". Then: "In addition to these handicaps to
20 our present program, other facilities are vitally needed.
21 Such facilities include the organization of domiciliary
22 visiting by qualified psychiatric social workers and, if
23 necessary, psychiatrists before admission is suggested".
24 On the assumption that you are familiar with the provisions
25 of the Health Services Act, the Physicians Act which was
26 recently passed by the Legislature ---

27 DR. COBURN: Yes.

28 THE CHAIRMAN: Would such visiting by
29 psychiatrists before admission as suggested come within the
30 scope of the Act as a pre-paid service?



DR. GOSWAMI: Thank you very much, Sir.

GOVERNOR: Is there anything further that you wish to add?

DR. GOSWAMI:

DR. GOSWAMI: I don't think so, Sir.

GOVERNOR: No, Sir, I think that is all.

Information is in the brief.

THE GOVERNOR: There is something about it.

GOVERNOR: I don't know, if you would, please speak up.

GOVERNOR: You say, the existing law, the early expenditure

for patients, and the short-sighted nature of the policy

of the Government and the short-sighted nature of the

personnel who are the cause of the situation.

of the present law, the Government, the Government of the

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DR. GOSWAMI: Yes.

THE GOVERNOR: Would you mind visiting by

the present law, the Government, the Government of the

some of the Act as a pre-paid service?



1 DR. COBURN: I think this is somewhat of a
2 moot point.

3 THE COMMISSIONER: Is it spelled out in the
4 Act, or somewhere?

5 DR. COBURN: It is not spelled out in the
6 Act. There is an exclusion section of the Act, and people
7 excluded under the Act include those covered by the Mental
8 Health Act, so those people who would come under the juris-
9 diction of Dr. Lawson's Department would not come under
10 the Medical Care Act. However, there is another provision
11 in the Act which says that every specialist service will be
12 paid for, and if that is interpreted to mean the services
13 of the practising psychiatrist in the community, this would
14 come under the Act.

15 THE CHAIRMAN: Is this something of sufficient
16 importance that it should not be left to interpretive doubt,
17 or it should be spelled out. What is your opinion on that?

18 DR. COBURN: I think we have attempted to
19 have this matter clarified.

20 THE CHAIRMAN: Because if by visits from
21 psychiatrists before admission, and admission may not be
22 necessary or something of that kind, it may well be a
23 matter of very considerable importance?

24 DR. COBURN: In two British instances I
25 know of, they have been able to reduce the admission rate
26 by almost 50% by this technique.

27 DR. LAWSON: May I add, Mr. Chairman, that
28 in our scheme for community services we do intend to include
29 service at the home and the outpatient and the inpatient
30 phases, so that while the program is not included in the

DR. COHEN:

THE COMMISSIONER: It is possible

that the Commission

DR. COHEN: It is not spelled out in the

8 Health Act, so those people who would come under the jurisdiction

9 of the Department would not come under

10 the Medical Care Act. However, there is another provision

11 in the Act which says that every registered service will

12 be paid for, and it is that is interpreted as the service

13 of the practicing physician in the community. This would

14 come under the Act.

15 THE COMMISSIONER: In this connection of public

16 importance that it would not be left to interpretive

17 DR. COHEN: I think we have attempted to

18 have the matter clarified.

19 psychological factors, and education may not be

20 necessary or something of that kind, it may well be a

21 matter of very considerable importance.

22 DR. COHEN: In two other instances

23 of, they have been able to reduce the education to

24 by almost 50% by this technique.

25 DR. LAWSON: May I add, Mr. Chairman, that

26 in our scheme for community services we do intend to

27 service at the same and the outpatient and the inpatient

28 cases, so that while the program is not included in the



1 Act, it still is possible for this to be maintained as
2 it is now, a separate service under the Government if they
3 so desire.

4 COMMISSIONER McCUTCHEON: The Minister, in
5 reply to a question I asked on Tuesday, said that the
6 interpretation was that psychiatric services are included
7 under the first heading of Physicians' Services. What
8 psychiatric services, in your opinion, Dr. Lawson, was he
9 referring to, if there are these other exclusions?

10 DR. LAWSON: I think he was referring to
11 those who are doing psychiatric work in a private capacity,
12 private practitioners of psychiatry.

13 COMMISSIONER McCUTCHEON: Then can there be
14 any question that a psychiatrist visiting me in my home
15 wouldn't be paid?

16 DR. LAWSON: Not if this interpretation of
17 other specialists includes psychiatrists, and if that first
18 part about special services includes psychiatrists.

19 COMMISSIONER McCUTCHEON: Well then, there
20 may have been some significance in them dropping the item
21 psychiatric services from the recommendations in the
22 Thompson Report when the definition of insured services
23 was put in the Act?

24 DR. LAWSON: There is a possibility. I
25 don't know. There was a little different wording in the
26 draft of that Bill, which we brought to their attention,
27 but I think the main intention was not to include the
28 presently supplied Government Services in psychiatry with
29 the rest of medicine.

30 THE CHAIRMAN: Well, does the present-day



1 services in psychiatry include what you are talking about
2 here, that is visiting by psychiatrists . . . That must in-
3 clude psychiatrists in private practice called by the
4 patient, or by the family, before the patient comes to the
5 notice or attention of the Mental Health Department at all?

6 DR. McLURG: These services are available
7 to the public from private practitioners, but under Govern-
8 ment auspices, and only to a limited extent through private
9 plans.

10 THE CHAIRMAN: But under the new Act in
11 Saskatchewan, are those services going to be covered? That
12 is what we want to know.

13 DR. McLURG: This is a matter of doubt,
14 unless they are included as special services.

15 THE CHAIRMAN: Who is going to resolve this
16 doubt?

17 DR. McLURG: I presume this will be a matter
18 for the Commission to determine.

19 COMMISSIONER McCUTCHEON: With the approval
20 of the Lieutenant Governor in Council. So there may still
21 be some private practising physicians in Saskatchewan
22 after the new Act comes into force if this doubt is not
23 resolved in favour of the patient?

24 DR. McLURG: I presume so, yes.

25 THE CHAIRMAN: It is rendering service to
26 people who are ill, but for who will not be paid for under
27 the program for the rendering of that service?

28 DR. McLURG: It will depend on whether the
29 person in private practice of psychiatry can render his
30 services and charge privately outside of the Plan.



3 include physician etc in private practice called for the
4 patients or of the family, before the patient comes to the
5
6
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10
11 THE CHAIRMAN: But under the new Act is
12 Shaferstein and those persons going to be covered? The
13 is what we want to know.
14 DR. MILLER: This is a matter of doubt.
15 unless they are included in general services.
16 THE CHAIRMAN: Who is going to review this
17 donor?
18 DR. MILLER: I presume that will be a matter
19 for the Commission to determine.
20
21 of the Department of Health and Human Services, so they may still
22 be some private group of physicians in Shaferstein
23 after the new Act comes into force if this doubt is not
24 resolved by the Commission.
25 DR. MILLER: I presume that will
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27 people who are still, for who will not be paid for their
28 the program for the rendering of that service?
29 DR. MILLER: It will depend on whether it
30
31 services and charge privately outside of the plan.



1 THE CHAIRMAN: How big an area in volume
2 could that occupy, having regard to the statements you
3 make in this Brief that a conservative estimate is that
4 33% of the population suffer from emotional disorders, and
5 that a great number of those who go to the general prac-
6 titioner go not because of physical disorder, but because
7 of some emotional disorder?

8 DR. McLURG: Mr. Chairman, do you mean in
9 numbers of patients?

10 THE CHAIRMAN: Yes, in the percentage and/or,
11 as Mr. Firestone suggests, in the time spent by the physician

12 DR. McLURG: Well, I can only clarify that
13 in this way that in the Province there are four of us in
14 private practice of psychiatry. We are very busy full-time
15 at this particular aspect of medicine, and I am quite sure
16 that there is room for several more privately practising
17 psychiatrists outside of the Government supplied services.
18 That is, there is ample demand for our services in this
19 field.

20 COMMISSIONER McCUTCHEON: Does the Government
21 today supply any service in the field of psychiatry outside
22 of its own institutions? If so, could you tell us what it
23 is, Dr. Lawson?

24 DR. LAWSON: The Government has followed a
25 policy, rather slowly in my opinion, but that is my own
26 opinion, of establishing outpatient clinics, or mental
27 health clinics throughout the Province. These usually take
28 the form of a part-time clinic, that is a one-day a week
29 clinic, to start with. They provide an out-patient service
30 in a community. They do not usually have any beds that

THE CHAIR

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6 stationer do not because of

7 of some emotional disorders

8 DR. McLENNAN: Yes, Chairman, do you mean in

9 numbers of patients?

10 MR. CHAIRMAN: Yes, in the percentage and

11 as Mr. Friesen suggests, in the time spent by the patients

12 DR. McLENNAN: Well, I can only say that

13 in this way sent to the hospital there are 10 or 12 in

14 private practice of psychiatry. We are very busy people

15 at this particular season of medicine, and I am quite sure

16 that there is some for several more privately practicing

17 psychiatrists outside of the government employed services

18 that is, there is some demand for our services in this

19 field.

20 COMMISSIONER McLENNAN: Does the government

21 today supply any service in the field of psychiatric outside

22 of its own institutions? If so, could you tell me what it

23 is, Mr. McLENNAN?

24 DR. McLENNAN: The government has followed a

25 policy, neither actively in my opinion, but that is my own

26 opinion, of establishing outpatient clinics, or mental

27 health clinics throughout the Province. These usually have

28 the form of a part-time clinic, that is a one-day a week

29 clinic, as a rule. They provide an outpatient service



1 they can utilize. These people are often called into
2 consultation within the homes. This has been our attempt
3 to gradually increase the scope of psychiatric service
4 provided to the people.

5 COMMISSIONER McCUTCHEON: What would the
6 staff of a clinic be?

7 DR. LAWSON: Ideally it is two psychiatrists,
8 two social workers, a psychologist, and stenographic staff.

9 COMMISSIONER McCUTCHEON: How many such clinics
10 are there?

11 DR. LAWSON: There is one with the two and
12 six others with one psychiatrist, and one social worker.

13 COMMISSIONER McCUTCHEON: No psychologist?

14 DR. LAWSON: With the psychologist, but not
15 the double ---

16 COMMISSIONER BALTZAN: Do you understand,
17 it is not for us to take issue, but rather to learn from
18 you, and to be informed, and it is in that frame of mind
19 that I direct some of the questions.

20 First, are there more psychiatrics now than
21 formerly, and I use it in the medical sense, psychiatrics
22 as against the neurotics?

23 DR. COBURN: It is difficult to get reliable
24 statistics regarding the number of psychiatrics. The pro-
25 blem is dependent upon the facilities for their treatment.
26 If you have good facilities for the treatment, you identify
27 some of them. If you have poor facilities they are kept
28 at home, but there is experience to suggest that there has
29 been an increase in psychiatrics, largely because of the
30 age distribution in our population. We are now having



1. The first question is: What is the purpose of the study?

2. The second question is: What are the objectives of the study?

3. The third question is: What are the methods of the study?

4. The fourth question is: What are the results of the study?

5. The fifth question is: What are the conclusions of the study?

6. The sixth question is: What are the implications of the study?

7. The seventh question is: What are the limitations of the study?

8. The eighth question is: What are the strengths of the study?

9. The ninth question is: What are the future directions of the study?

10. The tenth question is: What are the key findings of the study?

11. The eleventh question is: What are the main contributions of the study?

12. The twelfth question is: What are the practical applications of the study?

13. The thirteenth question is: What are the theoretical implications of the study?

14. The fourteenth question is: What are the policy implications of the study?

15. The fifteenth question is: What are the ethical considerations of the study?

16. The sixteenth question is: What are the social implications of the study?

17. The seventeenth question is: What are the environmental implications of the study?

18. The eighteenth question is: What are the economic implications of the study?

19. The nineteenth question is: What are the cultural implications of the study?

20. The twentieth question is: What are the political implications of the study?

21. The twenty-first question is: What are the legal implications of the study?

22. The twenty-second question is: What are the moral implications of the study?

23. The twenty-third question is: What are the philosophical implications of the study?

24. The twenty-fourth question is: What are the religious implications of the study?

25. The twenty-fifth question is: What are the spiritual implications of the study?

26. The twenty-sixth question is: What are the psychological implications of the study?

27. The twenty-seventh question is: What are the physiological implications of the study?

28. The twenty-eighth question is: What are the behavioral implications of the study?

29. The twenty-ninth question is: What are the cognitive implications of the study?

30. The thirtieth question is: What are the emotional implications of the study?



1 more people live to the age where senile disease occurs,
2 so we have more people living to the age of that group than
3 in the fifties.

4 COMMISSIONER BALTZAN: So that the shift is
5 due to the fact of the longevity of ---

6 DR. COBURN: This has been produced by good
7 medicine. COMMISSIONER BALTZAN: It is not bitter medicine
8 Good medicine. Number two, do the psychiatrics stay con-
9 fined to institutions for a shorter time now?

10 DR. COBURN: A much shorter time now. To
11 quote my own institution, our average length of stay now
12 is twenty-two days.

13 COMMISSIONER BALTZAN: Therefore, I ask you
14 are there not more reasons for optimism than the current
15 alarm and pessimism about the mentally disturbed?

16 DR. COBURN: I think there is more cause
17 for optimism now than there has ever been. We now have
18 techniques and knowledge which I think can go a long way to
19 substantially improving our mental hospitals, but we do
20 require the personnel to put these already known techniques
21 into operation.

22 THE CHAIRMAN: Unless you have that, the
23 condition ---

24 DR. COBURN: The condition will continue.

25 COMMISSIONER BALTZAN: That sure is wonder-
26 ful news, and if that was disseminated I think it would be
27 a great tranquilizer among the people, wouldn't it?
28 "Psychiatric education must be supported in the medical
29 schools by inclusion of Psychiatry in IMCC ---", and you
30 want that done on the basis of a subject?



COMMISSIONER BATTMAN: So that the white

due to the fact of the locality of --

MR. COBBIN: This has been produced by good

medicines. COMMISSIONER BATTMAN: It is not better medicine

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want that done on the basis of a subject?



1 DR. COBURN: Yes, sir.

2 COMMISSIONER BALTZAN: Would you not say if
3 psychiatry compares equally with the organic disturbances,
4 that if the questions in general medicine were not say,
5 equal rather than separate subjects, we have examples like
6 that, and even our Dominion Council, there are only four
7 questions in the whole field to become a specialist -- I
8 am questioning whether it is your opinion that it is imper-
9 ative whether there should be a separate subject in the
10 examination?

11 DR. COBURN: I believe it is imperative.
12 The only alternative I think would be to have just one
13 examination with sub-sections on obstetrics and gynecology.
14 If you have separate examinations for obstetrics and
15 gynecology, surgery and medicine, and you don't have a
16 separate examination for psychiatry, it immediately puts
17 it into an inferior position in the eyes of a student. It
18 is not as important as the ones that have separate examina-
19 tions. The students are very quick, and they also tend to
20 distribute their study, the time in terms of what they have
21 to do in examinations, and if we want to have them put the
22 emphasis of their studies on psychiatry, this must count as
23 much in their total grades as any other subject.

24 THE CHAIRMAN: Dr. Coburn, I might as well
25 tell you and your associates here this morning that this
26 Commission has set up an educational project under Dr.
27 McFarlane, the retired Dean of the School of Medicine of
28 the University of Toronto, and your observations regarding
29 medical education will go to that Committee, and I am
30 sure that you will be hearing from that Committee for



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that if the questions in general medicine were not easy,

that, and even our Dominion Council, there are only four
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It is not as important as the ones that have separate
titles. The students are very dumb, and they also tend to
obscure their study, the time in terms of what they have
studied in their field, given as any other subject.

THE CHAIRMAN: Dr. Cochran, I might as well
say that you have set up an educational project under Dr.
McFarlane, the retired Dean of the School of Medicine of
and that you will be hearing from that Committee for



1 recommendations as to the curriculum in the medical courses,
2 and you will have the opportunity there to stress this, so
3 that it won't be overlooked.

4 Your Brief and your recommendations today
5 will go to that Project Committee.

6 COMMISSIONER: BALTZAN: Dr. Coburn, the
7 psychiatrist today is the poorest paid of the medical
8 specialists. We don't want to know in terms of dollars and
9 cents, but how does it compare with the internist and simi-
10 lar specialists?

11 DR. COBURN: The remuneration of psychiatrists
12 runs at about two-thirds of what the other specialists are
13 getting. We have documented some comparisons in our
14 Brief, but I think that roughly speaking the psychiatrist
15 is getting about two-thirds of what other specialists are
16 making. Of course, there is wide variation in what other
17 specialists are making, so this is a generalization.

18 COMMISSIONER BALTZAN: How does that compare
19 with the capital expenditure for conducting the other types
20 of practice, as against the carrying on of your specialty?

21 DR. COBURN: The capital expenditure, I
22 suppose, consists of two parts: Firstly, the expenditure
23 in your educational program -- the number of years devoted
24 to it.

25 COMMISSIONER BALTZAN: Which is greater?

26 DR. COBURN: Preparation in psychiatry is
27 four years; that is, four years after rotating internship;
28 so, it is five years after college.

29 COMMISSIONER BALTZAN: How does that compare
30 with medicine?



1 and the doctor DR. COBURN: I believe it is the same.

2 and does seem COMMISSIONER BALTZAN: Dr. Coburn, the
3 treatment of the mentally ill is far below standards: You
4 mention that it has actually improved greatly. The treat-
5 ment is below standards not because of the kind of therapy,
6 but because perhaps of the kind of accommodation; is that
7 what you mean?

8 some matter DR. COBURN: It is basically accommodation,
9 per diem rates, space allotment per bed, the staff-patient
10 ratio, the number of doctors per 100 patients in the hos-
11 pital, and remuneration of the physicians.

12 and the COMMISSIONER BALTZAN: You mentioned earlier
13 and I have forgotten -- what is the ratio of bed occupancy
14 of the mentally emotionally disturbed versus the general
15 occupancy in hospitals?

16 and the DR. COBURN: In Saskatchewan the aimed at
17 occupancy rate in hospitals is eighty percent. The occup-
18 ancy rate at our two large mental hospitals in terms of
19 rated capacity is very close to 150%.

20 COMMISSIONER BALTZAN: I am not talking
21 about that, Doctor: The number of beds occupied by the
22 mentally ill versus the number occupied by the non-mentally
23 ill?

24 and the DR. COBURN: It is very close to equality
25 in numbers. There are approximately 75,000 mental hospital
26 beds in Canada, and 75,000 general hospital beds.

27 and the THE CHAIRMAN: That figure has been broad-
28 cast very widely.

29 and the DR. COBURN: We get sick of saying it, sir.

30 and the COMMISSIONER BALTZAN: Dr. Coburn, I am very



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treatment of the mentally ill is far below standards: You mention that it has actually improved greatly. The first point is below standards not because of the kind of therapy but because perhaps of the kind of accommodation; is that what you mean?

DR. COBURN: It is basically accommodation, per diem rates, space allocation per bed, the staff-patient ratio, the number of doctors per 100 patients in the hospital, and remuneration of the physicians.

COMMISSIONER BARTMAN: You mentioned earlier and I have forgotten -- what is the ratio of bed occupancy of the mentally emotionally disturbed versus the general occupancy in hospitals?

DR. COBURN: In Saskatchewan the aimed at occupancy rate in hospitals is eighty percent. The occupancy rate at our two large mental hospitals in terms of rated capacity is very close to 100%.

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DR. COBURN: It is very close to equality in numbers. There are approximately 75,000 mental hospital beds in Canada, and 75,000 general hospital beds.

DR. COBURN: We get sick of saying it, sir. COMMISSIONER BARTMAN: Dr. Coburn, I am



1 bad at statistics and I am certainly bad at figures, but
2 that does sound very alarming, and has a certain implica-
3 tion. I tried to do a little mental arithmetic last night,
4 and I just pose this: 100 hospital beds for psychotics
5 for 100 days -- they usually stay longer than anybody else --
6 will accommodate 100 patients; and one bed of the non-
7 psychotic is even less than ten days -- therefore, the
8 same number of beds for psychotics as for the non-psychotic
9 100 beds will accommodate about 1,000 patients?

10 DR. COBURN: That is correct.

11 COMMISSIONER BALTZAN: My arithmetic may be
12 wrong, but the idea is correct?

13 DR. COBURN: The general concept is certain-
14 ly right. I think in the last submission of the Psychiatric
15 Nurses they made the statement that 75% of the psychiatric
16 patients had been there two years or longer. The propor-
17 tion of patients in general hospitals who have been there
18 for two years or longer is infinitesimal; it practically
19 doesn't exist.

20 COMMISSIONER BALTZAN: In other words, the
21 incidence, I ask you, cannot be judged on a basis of just
22 putting figures before you such as bed occupancy?

23 DR. COBURN: The number of beds is not an
24 index of the incidence. To make an index of the incidence
25 you have to also rate the turnover.

26 COMMISSIONER BALTZAN: That is right; I want
27 to be corrected on these things. One other thing: "As to
28 the prevalance of the neuroses, it has been estimated that
29 ten to sixty percent of the general practictions' patients
30 suffer from illnesses based primarily on disturbances of



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ten to sixty percent of the general population; patien
suffer from illnesses based primarily on disturbances of



1 an emotional sort..." It has been said -- and we believe
2 some of the things that one reads -- that, at least south
3 of the border it is said that 60% of the patients who go
4 to doctors' offices suffer from emotional disturbances
5 rather than from the old, traditional organic diseases?

6 in the people. DR. COBURN: I would suspect that figure is
7 a little too high; that it would probably be closer to
8 40%, but this may well represent 60% of the doctors' time
9 because this type of patient is more time-consuming.

10 to him. It is. COMMISSIONER BALTZAN: I am talking in terms
11 of the number of patients rather than time expended. Of
12 this 60% is it true to say that 90% of their problems can
13 be handled by a competent understanding physician, rather
14 than needing a psychiatrist?

15 to him. DR. COBURN: I am not sure of an exact per-
16 centage figure, but I feel perfectly safe in saying a
17 large proportion of their problems could be handled by a
18 competently trained general practitioner. We have some
19 reasons to state this with fair assurance: We have had a
20 general practitioner on our staff in the psychiatric ward
21 of the University Hospital, and he has proved perfectly
22 competent to handle the psychiatric problems of his patients
23 with a very minor assist from us.

24 to him. COMMISSIONER BALTZAN: Dr. Coburn, you state
25 here a conservative estimate is that 33% of the population
26 suffer from these things that we are talking about: Do you
27 mean of the total population, or 33% of the patients that
28 go to see doctors?

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30 one third of the people will in a year consult a physician



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26 suffer from these things that we are talking about; by a
27 mean of the total population, or 33% of the patients that
28 go to see doctors?
29 DR. COBURN: Of the total population --
30 one third of the people will in a year consult a physician



1 for a complaint which is basically emotional in origin.

2 COMMISSIONER BALTZAN: Would you say that
3 a lot of these disturbances -- shall I phrase it something
4 like this: Is the lack of tranquility more exogenous than
5 endogenous? Is it the inner disturbance that takes place
6 in the people, or is it the outside forces in our society,
7 in our way of life?

8 DR. COBURN: I don't think I am qualified
9 to make that distinction. It is always a composite of
10 both. It is whether your inner resources can deal with the
11 outer stresses, and I don't think I can answer that ques-
12 tion.

13 COMMISSIONER BALTZAN: I don't put it for
14 any other reason except that I am thinking in terms of
15 personnel. There is a shortage, and if other things were
16 looked after, and other aspects, that shortage, which is
17 fairly serious, would be lessened by attending to the other
18 forces.

19 DR. COBURN: Yes; possibly some of the other
20 problems are more difficult of solution, however, than the
21 psychiatric ones.

22 THE CHAIRMAN: Dr. Coburn, there is one
23 small area in connection with mental illness, and that is
24 the custodial care of the criminally insane. What recom-
25 mendations would your Association have to make in regard
26 to that class -- admittedly, a small class?

27 DR. COBURN: I wonder if I may speak for
28 myself on this, because I don't think I am empowered by the
29 Association to give their opinion. I think it is grossly
30 unfair to our hospital system to force our hospitals to

for a complaint which is basically emotional in origin.

COMMISSIONER BARTMAN: Would you say that

a lot of these disturbances -- shall I phrase it somewhat

like this: Is the lack of tranquility more exogenous

andogenous? Is it the inner disturbance that takes place

in the people?

to our way of life?

DR. COBBIN: I don't think I am qualified

to make that distinction. It is always a composite of

both. It is whether your inner resources can deal with the

outer stresses, and I don't think I can answer that ques-

tion.

COMMISSIONER BARTMAN: I don't put it for

any other reason except that I am thinking in terms of

personal. There is a shortage, and if other things were

looked after, and other aspects, that shortage, which is

very serious, would be lessened by attending to the other

things.

DR. COBBIN: Yes, possibly some of the other

problems are more difficult of solution, however, than the

psychiatric ones.

THE CHAIRMAN: Dr. Coburn, there is one

more in connection with mental illness, and that is

DR. COBBIN: I wonder if I may speak for

most of the time, because I don't think I am empowered by the

Association to give their opinion. I think it is grossly



1 give this sort of penal custodial care. As soon as you
2 do that, it ceases to be a hospital and becomes a jail,
3 and my own feeling is that these people should be housed
4 in the jails...

5 THE CHAIRMAN: Even though they are mentally
6 ill?

7 DR. COBURN: Even though they are mentally
8 ill. I am sorry, I didn't quite finish my sentence:
9 ...housed in the jails in special hospital facilities. If
10 I am in jail and take physically ill, they put me in the
11 jail hospital and they have facilities for treating me.
12 If I became mentally ill, I would expect them to have
13 facilities for treating my mental illness and treating it
14 properly. But, I think we should rid our mental hospitals
15 of this burden.

16 THE CHAIRMAN: It comes up in two aspects,
17 as you are no doubt familiar: There is a person who is
18 brought before the Court regarding whom there is doubt as
19 to whether he is fit or not to stand trial, and he may be
20 committed to the mental institution for a period of thirty
21 day for examination and a report. What about that individual
22 There are more of those than of any other, from the nature
23 of things?

24 DR. COBURN: These people cannot be consider-
25 ed criminally insane because they have not been convicted.

26 THE CHAIRMAN: That is right.

27 DR. COBURN: So they can be handled on a
28 very similar basis to other patients in the admitting ward
29 of a mental hospital.

30 THE CHAIRMAN: But there is a question of

1 give this sort of mental analgesic care. As soon as you
2 do that, it ceases to be a hospital and becomes a jail.

DR. CORNUM: Even though they are mentally

4 ill. I am sorry, I didn't quite finish my sentence. I
5 housed in the jail in special hospital facilities. It

10 facilities for treating my mental illness and treating it
11 properly. But, I think we should add our mental hospitals
12 of this nature.

THE CHAIRMAN: It comes up in two aspects,

14 as you are no doubt familiar: There is a person who is
15 brought before the Court regarding whom there is doubt as
16 whether he is sane or insane. He is committed to the mental institution for a period of ninety

17 days for examination and a report. What about that individual

22 ed criminally insane because they have not been convicted.

THE CHAIRMAN: That is right.

DR. CORNUM: So they can be handled on a



1 custody involved, as you will appreciate.

2 DR. COBURN: Yes, I realize that. We have a
3 new Act in Saskatchewan with regard to this: They can be
4 sent to an outpatient facility for examination.

5 THE CHAIRMAN: Well, unfortunately, the
6 criminal law conditions are contained in the Code and not
7 in the Saskatchewan Act.

8 DR. LAWSON: May I make one point on that?

9 THE CHAIRMAN: Yes.

10 DR. LAWSON: This provision in the Saskat-
11 chewan Act has cut down, or is intended to cut down, and
12 is, I think, cutting down the number of people that have
13 to go for the thirty day observation period. It has
14 It has reduced this number even further, because there are
15 other provisions under this Act. The Criminal Code still
16 maintains the observation, and so do we, but it is provided
17 in the Mental Health Act for the outpatient examination of
18 the individual, and if it is obvious this person does not
19 need observation, and the diagnosis can be made there ---

20 THE CHAIRMAN: You get a quick diagnosis.
21 I know you are not in a position, not having given the
22 matter prior consideration, to deal with that, but would
23 you care to take the matter under consideration and let us
24 know if, having regard to the provisions of the Criminal
25 Code as to custody of those who having been charged with a
26 crime are found not guilty but insane --- if you would have
27 any recommendation to make, and if you would be good
28 enough to send them to us at a later date.

29 DR. COBURN: We would be very pleased to.

30 COMMISSIONER VAN WART: Dr. Lawson, your



DR. COBURN: Yes, I realize that. We have

now not in Saskatchewan with regard to this: They can be sent to an outpatient facility for examination.

in the Saskatchewan Act.

DR. LAWSON: May I make one point on that?

DR. LAWSON: This provision in the Mental

Health Act has not been put down, or it has been put down, and

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to go for the thirty day observation period.

maintains the observation, and so do we, but it is provided in the Mental Health Act for the outpatient examination of the individual, and if it is obvious that person does not need observation, and the diagnosis can be made there -- THE CHAIRMAN: You give a quick diagnosis.

I know you are not in a position, not having given the matter prior consideration, to deal with that, but would you care to take the matter under consideration and let us know it, having regard to the provisions of the Criminal Code as to custody of those who have been charged with a crime and found not guilty but insane -- if you would have any recommendation to make, and if you would be good enough to send them to us at a later date.

DR. COBURN: We would be very pleased to.

COMMISSIONER VAN WAGEN: Dr. Lawson, your



1 outpatient clinics: Have you trouble in retaining your
2 psychiatrists?

3 DR. LAWSON: We have had a fair amount of
4 trouble in retaining our psychiatrists in all areas, Mr.
5 Commissioner. The outpatient clinics probably fare a
6 little better than some of the other positions.

7 COMMISSIONER VAN WART: Where do these
8 psychiatrists go when they leave you?

9 DR. LAWSON: They go to various places:
10 Some of them go to other Provinces, a lot of them go to
11 the States. Some of them go into private practice in more
12 thickly populated areas.

13 COMMISSIONER VAN WART: Most of them go to
14 the United States?

15 DR. LAWSON: I would say probably.

16 COMMISSIONER VAN WART: Do they ever give
17 you reasons why they leave?

18 DR. LAWSON: There are a number of reasons.
19 I think we have set forth in the Brief here the same con-
20 ditions that apply in recruitment, and I think these apply
21 in regard to attrition of professional personnel. There is
22 a question of remuneration, which is the most important
23 thing to some people, and the question of the level of the
24 program. If an individual can be given a program which is
25 challenging and exciting, he is liable to stay. We lost
26 one very good one a year ago who got tired of waiting for
27 our community program. These various factors will vary
28 with the individual: The individual who is raising a
29 flock of children will perhaps have a little more bias
30 towards a larger salary; and the individual who is really



61 little better than some of the other positions.

COMMISSIONER VAN WART: Where do these

8 specialists go when they leave you?

9 DR. LAWSON: They go to various places:

10 Some of them go to other provinces, a lot of them go to

11 the States. Some of them go into private practice in more

12 strictly populated areas.

13 COMMISSIONER VAN WART: Most of them go to

14 the United States?

15 DR. LAWSON: I would say probably.

16 COMMISSIONER VAN WART: Do they ever give

17 you reasons why they leave?

18 DR. LAWSON: There are a number of reasons.

19 I think we have met some in the field have the same con-

20 ditions that apply in recruitment, and I think these appli-

21 in regard to attraction of professional personnel. There

22 a question of remuneration, which is the most important

23 thing to some people, and the question of the level of the

24 program. If an individual can be given a program which is

25 challenging and exciting, he is likely to stay. We lost

26 one very good one a year ago who got tired of waiting for



1 the type we want most will pay more attention to the type
2 of program with, at the same time, some sort of adequate
3 remuneration.

4 THE CHAIRMAN: Thank you very much, gentle-
5 men. As I said, the record of what you have said this
6 morning and your submission in addition to going to our
7 research staff will also go to the medical education pro-
8 ject under Dr. McFarlane.

9 DR. COBURN: Thank you very much for your
10 interest, sir.

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SUBMISSION OF

GROUP MEDICAL SERVICES

APPEARANCES:

MR. C.F. ADSHEAD

DR. FINKELSTEIN

MR. J. A. BROWN

---EXHIBIT NO. 99:07 1000 Brief of Group Medical Services.

MR. ADSHEAD: Mr. Chairman, Members of the Commission, I would like to say we appreciate the opportunity of appearing before you, and would now like to read the pages of our summary.

1. We are in fullest sympathy and agreement with any undertaking which has as its objective the improvement of methods, resources and services with which to better fulfill the health needs of Canadians.
2. We join with other agencies and organizations concerned with health matters in pledging our wholehearted co-operation to the Royal Commission conducting this important investigation of health care.
3. Group Medical Services of Regina welcomes the opportunity to make a submission to this study. In the following pages we have outlined the story of GMS and its development as a private, voluntary, non-profit, prepaid medical care plan. In this regard:
 - (a) GMS was formed in 1949, as the result of an amalgamation of two established prepaid medical care plans: Group Health Association Limited and Medical Services Incorporated (Regina). Group Health, a co-operative plan, and Medical Services, a doctor-



1 sponsored plan, had both offered medical and hospital
2 care programs for almost ten years prior to the
3 amalgamation.

4 (b) GMS introduced a unique partnership of lay-
5 man and doctor at the administrative level. It
6 brought together for the direction of its affairs
7 and the shaping of policy the two groups it repre-
8 sents -- subscribers and doctors. These people work
9 together as a democratically elected Board of
10 Directors.

11 (c) Through the years of its growth, GMS has
12 fulfilled its functions in all respects. Its expan-
13 sion reflects the acceptance of its service by the
14 public. The stability of its financial affairs has
15 been ensured by sound, businesslike fiscal policies
16 and emphasis on efficient, economical operation.
17 In over twelve years 90% of the money was
18 paid in medical bills.

19 (d) The GMS plan is constantly under review to
20 effect changes and modify restrictions in the inter-
21 ests of greater flexibility and wider application.

22 4. The physical structure and guiding philosophy of
23 GMS is based on the principle of voluntary partici-
24 pation in prepaid medical care plans. We believe
25 the health needs of our people can be met within
26 the framework of our free institutions.

27 5. We believe the extension of medical care to all
28 Canadians can best be served by utilizing the Canada-
29 wide services of existing voluntary plans. The
30 facilities and experience of established voluntary



(b) GMS introduced a unique partnership of laymen and doctors at the administrative level. It brought together for the direction of its affairs and the shaping of policy the two groups it represents - subscribers and doctors. These people worked together as a democratically elected Board of Directors.

(c) Through the years of its growth, GMS has fulfilled its functions in all respects. Its expansion reflects the acceptance of its service by the public. The stability of its financial affairs has been ensured by sound, businesslike fiscal policies and emphasis on efficient, economical operation. In over twelve years 90% of the money was used for medical care.

(d) The GMS plan is constantly under review to effect changes and modify restrictions in the face of changing conditions. The physical structure and guiding philosophy of GMS is based on the principle of voluntary participation in prepaid medical care plans. We believe the health needs of our people can be met within the framework of our free institutions. We relieve the extension of medical care to all Canadians can best be served by utilizing the Canadian services of existing voluntary plans. The facilities and experience of established voluntary



1 prepaid medical care plans are available to develop
2 a more universal program of medical care which need
3 not employ compulsion to be effective.

4 In this respect I would like to add that
5 we have co-operated fully with the Thompson Advisory Com-
6 mittee and rendered all the assistance we could in the
7 formation of their policies.

8 THE CHAIRMAN: You did make a submission to
9 that Committee?

10 MR. ADSHEAD: We made a submission and
11 recommendations.

12 THE CHAIRMAN: Is that available to us?

13 MR. ADSHEAD: Yes, sir, we will be pleased
14 to make a copy available to you.

15 6. The rapid growth of the voluntary plans in Canada
16 is a certification of their acceptance by the public
17 and confirmation of the useful service they have
18 rendered as an insurance medium.

19 7. We believe that the majority of Canadians have made
20 satisfactory arrangements for their health care or
21 have the resources to do so; that the provision of
22 adequate health care for all Canadians is essential-
23 ly the problem of supplying the needs of special
24 groups who, for financial or other reasons, are un-
25 able to obtain health care coverage; that this prob-
26 lem can be resolved by

27 --a measure of assistance to those who are
28 unable to provide for themselves;

29 --a joint effort of Government, the medical
30 profession and existing agencies to make



provision and existing agencies to

a joint effort of Government, the medical
groups and, for financial on other reasons, and in
this to obtain health care coverage; that this is
for the purpose of meeting the needs of special

patients, and that the medical community have a
We believe that the medical community have a
and a commitment of the medical community to have
is a certification of their acceptance by the public

MR. ALLISON: Yes, sir, we will be pleased
with the answer in that available to us?
RECOMMENDED: Yes.
MR. ALLISON: We made a submission and

THE CHAIRMAN: The committee will be
in the next few days, and we will be
in the next few days, and we will be
in the next few days, and we will be
in the next few days, and we will be



1 approved programs more readily and easily
2 available to our elder citizens and those
3 who have pre-existing medical conditions;
4 --an established schedule of standards and
5 principles which would govern the operations
6 of approved programs.

7 8. It is our submission that the foregoing recommenda-
8 tions constitute a sound basis upon which to build
9 a practical and economical program of health care
10 for Canadians.

11 9. We believe that a program which retains the princi-
12 ples of free choice and voluntary participation will:

13 (a) preserve individual initiative and enter-
14 prise, safeguard the traditional rights and freedoms
15 of patient and doctor, and maintain the present high
16 standards of medical care in Canada.

17 (b) readily accommodate the inclusion of a plan
18 or method whereby provision can be made for those
19 who are unable to provide for themselves.

20 (c) allow the Government to discharge its duties
21 in the field of health care without excessive cost.

22 (d) ensure that no area of health service is
23 deprived of funds because of heavy expenditure dir-
24 ected to the needs of one program.

25 (e) make possible more generous employment of
26 public monies for the institutional, treatment and
27 nursing care needs of the mentally ill, the aged,
28 and the chronically ill; for medical research and
29 other studies and services associated with the
30 development of good health care programs.



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a practical and economical program of health care
for Canadians.

We believe that a program which retains the principles of free choice and voluntary participation with
(a) preventive individual initiative and enter-

prise, safeguard the traditional rights and freedoms
of patient and doctor, and maintain the present high
standards of medical care in Canada.

(b) readily accommodate the inclusion of a plan
on method whereby provision can be made for those
who are unable to provide for themselves.

(c) allow the Government to discharge its duties
to ensure that no area of health service is

deprived of funds because of heavy expenditure directed to the needs of one program.
(d) make possible more generous employment of

and the chronically ill; for medical research and
other studies and services associated with the



1 10. GMS believe that Government can best serve the
2 health interests of the Canadian people by assist-
3 ing the needy and encouraging other citizens to pro-
4 vide for their own medical care through voluntary,
5 prepayment plans which subscribe to approved
6 standards and principles.

7 That is the summary of our presentation. I
8 would now like permission to file as an additional exhibit
9 a copy of our twelve financial annual statements.

10 THE CHAIRMAN: Exhibit Number 99A.

11 ---EXHIBIT NO. 99A: Copy of Twelve Annual Statements
12 of Group Medical Services.

13 MR. ADSHEAD: And we would file also a copy
14 of our Brief.

15 THE CHAIRMAN: Your submission to the
16 Thompson Committee? That will be Exhibit 99B.

17
18 ---EXHIBIT NO. 99B: Copy of Brief of GMS to Thompson
19 Committee.

20 THE CHAIRMAN: Now, Mr. Adshead, the sub-
21 missions you make here this morning I think are substantial-
22 ly the same, that is, recommendations and observations that
23 you made here this morning are substantially the same as
24 those you made to the Thompson Committee.

25 MR. ADSHEAD: Yes, sir. In one respect we
26 differ slightly in our submission this morning. In our
27 submission to the Thompson Committee we recommended volun-
28 tary prepayment on a regional basis with a local option
29 system. In view of the circumstances of the program being
30 suggested for the Province on a national scale we have not



preparation plans which substance to approved

standards and principles.

That is the summary of our presentation.

would now like permission to file as an additional exhibit

a copy of our twelve financial annual statements.

THE CHAIRMAN: Exhibit Number 29A.

Copy of Twelve Annual Statements
of Group Medical Services.

---EXHIBIT NO. 29A:

MR. ADKINS: And we would like also a copy

of our Exhibit.

Thompson Committee? That will be Exhibit 29B.

Copy of Brief of GMS to Thompson
Committee.

---EXHIBIT NO. 29B:

THE CHAIRMAN: Now Mr. Adkins, the sub-

missions you made here this morning I heard are substantiated

by the same, that is, recommendations and observations that

you made here this morning are substantially the same as

those you made to the Thompson Committee.

MR. ADKINS: Yes, sir. In one respect

after slightly in our submission this morning. In our

submission to the Thompson Committee we recommended vol-

untary preparation on a regional basis with local option

system. In view of the circumstances of the program being

suggested for the Province on a national scale we have not



1 gotten that far in making such a recommendation.

2 THE CHAIRMAN: And is it correct to say
3 that the majority report, the majority section of the
4 interim report rejected the idea of a voluntary premium in
5 development of a compulsory program?

6 MR. ADSHEAD: Yes, I think it is correct to
7 say that.

8 THE CHAIRMAN: We now know that the Statute
9 has been passed by the Legislature setting up a compulsory
10 program for the Province of Saskatchewan and we heard from
11 the Minister that it was the intention to bring that pro-
12 gram into operation at some time in the future. I think
13 the Minister expressed that he was hoping to bring it in
14 as of the 1st of April. Now, assuming that that comes
15 about, what will then be the position of an organization
16 such as yours if and when that program is set up and the
17 Act goes into operation?

18 MR. ADSHEAD: Our position is that we recom-
19 mended to our subscribers last night at our annual meeting
20 that as long as they are able to continue to belong to us
21 we hope to form an efficient and worth-while system for
22 them. If the subscribers should fall below the minimum
23 number, then we would have to re-examine our set-up. Our
24 intention is to do the best we can to provide for those
25 who wish a voluntary service.

26 THE CHAIRMAN: That is, a voluntary service
27 additional to the compulsory one?

28 MR. ADSHEAD: That would be correct.

29 THE CHAIRMAN: Now, are there areas not
30 covered, not contemplated to be covered by the compulsory



...in a ...

And is it correct to say

that the majority report, the majority section of the
interim report rejected the idea of a voluntary program in
development of a compulsory program?

...

I say that.

THE CHAIRMAN: We now know that the Statute
has been passed by the Legislature setting up a compulsory
program for the Province of Saskatchewan and we heard from
the Minister that it was the intention to bring that pro-
gram into operation at some time in the future. I think
the Minister expressed that he was hoping to bring it in
as of the 1st of April. Now, assuming that that comes
about, what will then be the position of an organization
such as yours is and when that program is set up and the

Act goes into operation?

...

THE CHAIRMAN: That is, a voluntary service

additional to the compulsory one?

MR. ASHHEAD: That would be correct.

THE CHAIRMAN: Now, are there areas not

...



1 system in which an organization such as yours could still
2 function such as providing insurance against contingencies
3 and things not covered by a compulsory plan?

4 MR. ADSHEAD: We believe that to be so.

5 We are making studies all the time and although the plan
6 is definitely involved, we cannot state with any degree of
7 certainty what our program would be, but we are studying this
8 situation all the time.

9 THE CHAIRMAN: For instance, nursing ser-
10 vices is one that might come readily to mind.

11 MR. ADSHEAD: Yes, we have a partial nursing
12 service of which we already provide for surgical operations
13 and no doubt that would certainly be studied for a further
14 extension.

15 THE CHAIRMAN: You will appreciate that in
16 the situation of the law having been passed and the announ-
17 ced intention to bring the plan into operation that the
18 status of a group such as yours in the Province that has a
19 compulsory plan must necessarily be one that would require
20 some re-examination.

21 MR. ADSHEAD: Yes, sir, we agree with that.

22 I would hope that as subscribers move slowly it need not
23 mean that such a plan as ours should wind up. I can
24 only speak from memory but it seems to me I read about two
25 years ago that voluntary plans such as ours in England have
26 been growing extensively. I say this figure subject to
27 correction, but I believe about 10% of the population have
28 enrolled in a plan such as ours since the compulsory plan
29 has been in effect in Great Britain and I would hope if a
30 compulsory plan is in effect in Saskatchewan that we will



10 view is one that might come readily to mind.

11 MR. WHELAN: Yes, we have a capital man

12 service of which we already provide for surgical operations

13 and no doubt that would certainly be studied for a further

14

15 THE CHAIRMAN: You will appreciate that in

16 the situation of the law having been passed and the amount

17 and duration of being the plan into operation that the

18 status of a group such as yours in a Province that has

19 compulsory plan was necessarily be one that would require

20

21 MR. WHELAN: Yes, sir, we agree with that.

22 I would hope that as suggestions move along it need not

23

24 only speak from memory but it seems to me I read about

25 years ago that voluntary plans such as ours in England have

26 been growing extensively. I say this figure subject to

27 correction, but I believe about 10% of the population in

28 enrolled in a plan such as ours since the compulsory plan

29 has been in effect in Great Britain and I would hope it is



1 be available for those who do not like that method of
2 compulsion.

3 THE CHAIRMAN: Well, you appreciate that
4 in England there is a procedure of contracting out which I
5 do not think is to be found in the Saskatchewan Statute.

6 MR. ADSHEAD: Possibly not right now, but
7 there is always a chance for a change of Government.

8 THE CHAIRMAN: Or a change of policy.

9 DR. FINKELSTEIN: I think it will probably
10 depend on our subscribers, the wishes of our subscribers.
11 It is interesting, I think, that in the past year -- I know
12 we are a reasonably small plan in comparison to many of the
13 plans in Canada, but it is interesting that our enrollment
14 in the past year increased by some 4,000 in view of every-
15 thing that happened in this Province. I think probably the
16 answer would rest primarily with the subscribers.

17 THE CHAIRMAN: Well, gentlemen, nobody
18 knows the future, but if the plan is brought into operation
19 and you have a month or two of experience in that new
20 atmosphere, would you be willing to give us at that time
21 your views in writing as to how things are then working
22 out for such a group as yours?

23 MR. ADSHEAD: Certainly, we would be very
24 glad to.

25 THE CHAIRMAN: Because this is a new
26 situation and you will have to anticipate that there will
27 be some experience there which perhaps some implications
28 might flow from. We would like to have your views and our
29 Secretary will be in touch with you in that regard at a
30 later time.



is not true as to be found in the Saskatchewan Statute
possibly not right now, but

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THE CHAIRMAN: Or a change of policy

MR. PRINCE: I think it will probably

depend on our representatives, the wishes of our subscribers

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THE CHAIRMAN: Well, gentlemen, nobody

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and you have a number of years of experience in that new

atmosphere, would you be willing to give us at that time

your view in writing as to how things are then working

out for such a group as yours

MR. PRINCE: Certainly, we would be very

THE CHAIRMAN: Because this is a new

situation and you will have to anticipate that there will

be some experience there which causes some implications



1 Now, in Saskatchewan there are three some-
2 what similar groups, they are not identical at all either
3 in their corporate construction or perhaps in their
4 coverage, but they are relatively similar and those are
5 your own group, MSI and the group known as Medical Co-op
6 in Saskatoon. Just how does it come there are three non-
7 profit essentially co-operative voluntary groups in one
8 Province as against the situation in Manitoba where there
9 is only one or in the Atlantic Provinces where the Maritime
10 Medical covers three Provinces?

11 DR. FINKELSTEIN: I think it is a matter of
12 history originally. I believe that the plans were local.

13 THE CHAIRMAN: Your own plan was an amalgama-
14 tion of two, why did the amalgamation process stop there?

15 DR. FINKELSTEIN: Well, it did not. An
16 attempt was made to amalgamate GMS and MSI and many, many
17 meetings were held. Actually meetings were suspended in
18 view of the Ex-Premier's statement some two years ago in
19 reference to a Province-wide compulsory plan and that
20 automatically terminated the process of amalgamation. The
21 schemes at that time were almost identical except for the
22 fact that we are covering only groups here and also admini-
23 ster several Municipal groups whereas MSI have their
24 individual contracts and community contracts as well a
25 group contract. Certainly amalgamation was very, very
26 close and I had it in my own mind that had the program not
27 been presented at the time it was that at this time we
28 would have been amalgamated. It was exceedingly close,
29 but immediately the Government's intention was known every-
30 body threw their hands in the air and all our work went



1 down the drain. We just left it there.

2 MR. ADSHEAD: May I add even in the joint
3 committee between the two plans there was a communication
4 to the Secretary of State of Canada for a charter or the
5 right to form a joint company. That right was denied,
6 because a charter had been given to the Trans-Canada
7 Medical Plans and in the opinion of the Secretary of State
8 only one company of that nature was necessary in Canada.
9 We were kind of frustrated there and, as Dr. Finkelstein
10 said, the matter has died for a while.

11 THE CHAIRMAN: Because there was the policy
12 announcement, is this what you are saying, because there
13 was the policy announcement that government would not deal
14 with you in any event?

15 DR. FINKELSTEIN: That was it. We were told
16 many, many times both in the Legislature and in the press,
17 radio and television that there was no place in this
18 Province, at any rate for the plans in the Government
19 scheme of things and it disillusioned us tremendously.

20 THE CHAIRMAN: Were any representations
21 made after the interim report of the Thompson Committee
22 came to Government to use voluntary plans as an adminis-
23 trative body to work out whatever plans the Government
24 might bring into being?

25 DR. FINKELSTEIN: Not actually for the
26 Thompson Committee, although during our submission to the
27 Thompson Committee we suggested a method whereby this could
28 be done from the point of view of a board of directorship.
29 We suggested as we are now, a board that is composed 50% of
30 lay people, subscribers and 50% of medical men, the provider



1 of the services. We suggested that Government could then
2 supply an equal number to the board and we would have what
3 in our assumption we thought would be a unique board in
4 the development of a pre-paid service to the people of
5 this province representing Government, the subscriber and
6 the doctor. Unfortunately this was not received favorably.

7 MR. HALL: Mr. Chairman, I notice in the
8 contracts that there is provision for amendment of the
9 subscription rate at the end of each month; in practice was
10 there much fluctuation?

11 MR. BROWN: No, sir, actually our present
12 rates have been in effect since February 1st, 1957.

13 MR. HALL: Was that provision intended to
14 cover your newer rate of subscription or on a group basis
15 if you had to apply it?

16 MR. BROWN: The intent would be to apply it
17 to the subscriber body as a whole.

18 THE CHAIRMAN: Thank you very much. In the
19 nature of things we will have to wait the developing events
20 and we will be in touch with you regarding further informa-
21 tion at a later date.

22 MR. ADSHEAD: Thank you very much, sir.

23 THE CHAIRMAN: We will take a short break
24 and proceed with the submission of the College of Medicine
25 of the University of Saskatchewan.

26

27 ---Short Recess

28

29

30



AG/ss

1 THE SECRETARY: The submission of the
2 College of Medicine, University of Saskatchewan will be
3 100; the Brief to the Advisory Planning Committee on
4 Medical Care of the Province of Saskatchewan dated December
5 the 31st, 1960, 100A; preliminary report on a survey Of
6 Saskatchewan Medical Students dated October 1961, 100B;
7 and the University teaching Hospitals additional Brief to
8 the College of Medicine, University of Saskatchewan, 100C.

9
10 ---EXHIBIT NO. 100: Submission of the College of
11 Medicine, University of
Saskatchewan.

12 ---EXHIBIT NO. 100A: Brief to the Advisory Planning
13 Committee on Medical Care of
14 the Province of Saskatchewan,
dated December 31st, 1960.

15 ---EXHIBIT NO. 100B: Preliminary Report on a Survey
16 of Saskatchewan Medical Students
dated October, 1961.

17
18 ---EXHIBIT NO. 100C: University Teaching Hospitals
19 additional Brief to the College
of Medicine, University of
Saskatchewan.

20
21 S U B M I S S I O N O F
22 THE COLLEGE OF MEDICINE, UNIVERSITY
23 OF S A S K A T C H E W A N

24 APPEARANCES:

25 DEAN J. W. MacLEOD

26 PROFESSOR A.A. BAILEY

27 DR. L. SWENSON

28 PROFESSOR I.M. HILLIARD

29 PROFESSOR G. J. MILLAR

30 PROFESSOR E.M. NANSON



1 DR. F. COBURN

2 PROFESSORY R.W. BEGG, ~~President~~ Chairman

3 PROFESSOR H. KEELER

4

5 THE CHAIRMAN: This is the first time I may
6 say, that I know everybody.

6

7 DR. BEGG: We are very appreciative. In our
8 Brief we have a small introduction, giving a small back-
9 ground of the assumptions under which we have written this
10 Brief, and have pointed out that we are one college of
11 the University, and are conscious of the valuable associa-
12 tions this permits us.

12

13 In the first ten pages of the Brief we have
14 certain conclusions and recommendations, and with your
15 permission I will condense these. We were concerned with
16 the requirement for personnel, and to make a realistic
17 appraisal we must know what the doctor is going to be
18 doing in the future. In order to permit us to get this,
19 we have made activity studies, if you will, to see what
20 doctors do today. People have pointed out some times there
21 is a difference between how we train doctors and when they
22 are involved in the practice of medicine. For this parti-
23 cular study we would recommend that a grant of \$20,000.00
24 be made to take care of research facilities and so forth,
25 and the travels involved therein.

25

26 We then make recommendations on the provi-
27 sion and training of personnel. We realize and share the
28 concern of others on the shortage of students in medicine,
29 but as a University group we are also concerned with the
30 Honours undergraduate in medical science, the student



say, that I know everybody.

DR. HEGG: We are very appreciative. In or

order we have a small introduction, giving a small back
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1 nurse, trainees in technology, therapy and social work,
2 and the provision of specialists. We feel that the require-
3 ment studies will in some degree tell us in which areas we
4 should concentrate on our training.

5 We feel that in all these areas there must
6 be a great improvement in the supply of personnel, and we
7 recommend that a study of reasons be made why men and
8 women do not select medicine or medical science as a
9 career. In practically all these, people are held back by
10 the lack of properly qualified personnel to undertake the
11 training. The first thing would be to get more and better
12 candidates for the health positions. We suggest that these
13 studies should be done by all of the colleges of medicine
14 across Canada, by the hospitals and the Royal Colleges.---

15 THE CHAIRMAN: Dean Begg, you are aware
16 that we have set up a Commission, a Section, under former
17 Dean McFarlane to do this very work for us, and I understand
18 that he was a Member of the Committee in Saskatoon some
19 time ago?

20 DR. BEGG: That is right. We go on to
21 detail the specific recommendations which would have to do
22 with the financial support of such students, because we
23 feel that this is a very complex situation in the factors
24 against us. The cost of education and length of time
25 required. These are not the only two things, but these are
26 two which can be approached, and about which we hope some-
27 thing can be done.

28 On the question of training of personnel,
29 we think that the Colleges of Medicine in Canada be encour-
30 aged and supported in research and medical education to



1 establish the optimum course content and the best method
2 of presentation by an experimental approach. That is, we
3 feel that in today's work we should make a re-appraisal of
4 our curriculum, and see if we cannot improve on the type
5 of things we teach, and how we teach them.-- proper teach-
6 ing hospitals. We have a very vigorous School of Nursing,
7 and we think that they need support in doing the type of
8 studies that they would like, such as the funds to be
9 allocated. The School of Nursing suggests that certain
10 studies should be made to help them eliminate their problem
11 and make fresh attacks on it, and a proposed cost estimate
12 is made of \$51,500.00.

14 In support of the submission of the Depart-
15 ment of Psychiatry, we recommend that mental illness be
16 treated in the same manner as any other illness in particu-
17 lar as concerns provision of physical facilities. At the
18 moment this is perhaps a limiting factor at the University
19 of Saskatchewan. Then on page 10 we have recommendations
20 as to medical research.

21 THE CHAIRMAN: Thank you, Dean Begg. Are
22 there any other observations or statements from any of the
23 other gentlemen who are with you here this morning?

24 DR. BEGG: They are quite free to speak, sir.

25 THE CHAIRMAN: They are quite free, and I
26 may say we are quite happy to hear from them.

27 DR. COBURN: I have already presented the
28 major portion of the psychiatric aspect of this Brief. I
29 would like just to emphasize two points. One is that the
30 undergraduate needs adequate education in psychiatry.



1 Many of us who graduated a few years back didn't receive
2 that. Secondly, if the general practitioner is to play
3 what we think is his proper role, he will require access
4 to hospital facilities for the treatment of his patients
5 with emotional problems.

6 PROF. KEELER: Mr. Chairman, I think I
7 could boil down our main problem in nursing, that what we
8 require is more freedom to select the experiences of our
9 students, so that we can carry these students from one
10 experience to another at higher levels. We believe we
11 could do this in a short time but we must have the freedom
12 to do that, but that is related to budget. I am sure
13 you have heard in the last few weeks something about 3.5.

14 THE CHAIRMAN: 3.4 is what we heard.

15 PROF. KEELER: The hospital budget is re-
16 lated to 3.4 hours of nursing care. The nursing students
17 are included in that, and that does restrict what we can do.
18 I am referring to specifically in my part of this Brief,
19 to our degree program, where our students, like any other
20 student, does two years in the hospital. We need a
21 hospital and the patients, and we don't despise at all
22 learning by doing, but we need the freedom to select, and
23 we need to answer questions on the teaching-learning pro-
24 gram.

25 We would like money given to say, the
26 Canadian Conference of Teaching Hospitals, and what are the
27 nursing needs of patients, and then they would tell us how
28 to prepare the nurse.

29 THE CHAIRMAN: Miss Keeler, I think I might
30 tell you now, I mean there is nothing confidential about it,



2 that. Secondly, if the general practitioner is to play
3 what we think is his proper role, he will require access
4 to hospital facilities for the treatment of his patients
5 with emotional problems.

6 PROF. KIBLER: Mr. Chairman, I think I
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8 require is more freedom to select the experiences of our
9 students, so that we can carry these students from one
10 experience to another at higher levels. We believe we

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12
13
14 THE CHAIRMAN: All right, what we heard.
15 PROF. KIBLER: The hospital doctor is re-
16 lated to 24 hours of working time. The nursing students
17 are restricted in that, and they don't realize what we can
18 do in referring to specifically in my case of this Brief.
19 to our degree program, where our students, like any other
20 student, get two years in the hospital. We need a
21 hospital and the practice, and we don't despise at all
22 learning by doing, but we need the freedom to select, and
23 we need to answer questions on the learning-learning pro-
24 gram.

25 We would like money given to ask, the
26 Canadian Conference of Teaching Hospitals, and what are
27 the needs of patients, and then they would tell us how
28 to prepare the nurse.



1 that we have, the Commission has set up studies in two
2 areas in connection with the nursing profession. The
3 first is one that you are probably familiar with. We are
4 really in a sense becoming a partner with the Canadian
5 Nursing Association in the Doctor Negley Survey and
6 Study, although contracted in point of perhaps even area,
7 and more particularly in point of time, and the subject of
8 his study is Nursing Education in Canada and the Utiliza-
9 tion of Nurses in Canada, and then a separate study, a
10 companion study. Dr. Negley, as you know, is in the
2 11 University of British Columbia. A companion study by an
12 associate of his in the University of British Columbia,
13 Dr. Robson, on the recruitment to the nursing profession.
14 and we hope in those studies to get a great deal of help
15 in answer to those questions you have raised this morning,
16 and because of having commissioned those studies, naturally
17 we are going to pass the nursing problems in the main to
18 our scholars, and to those who are going to be associated
19 with them in the studies, rather than attempt a detailed
20 examination of your submission, not only here but in
21 various other briefs that we are receiving across the
22 country, so we will make perhaps a less detailed examina-
23 tion of your project and your recommendations here than
24 would be otherwise the case, if we had not already commis-
25 sioned these studies, and they are actually in the process
26 of being done, and the same applies in a particular way to
27 the matter of medical education. Having got together what
28 we believe to be a very competent Committee, a group of
29 distinguished medical educators, under Dr. McFarlane, we
30 think it wise to leave it to them to gather what information



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think it wise to leave it to them to gather what informa-



1 they need, and for them to make recommendations to us,
2 and of course, we are looking for the fullest co-operation,
3 as we know we are going to get it, from all the medical
4 schools in Canada to Dr. McFarlane's Project Committee,
5 because naturally he has to go to the medical colleges for
6 ideas and suggestions and so forth.

7 ~~scribes other~~ The terms of reference under which that
8 Committee is operating are very broad in the sense of
9 medical education, and as with other briefs, where we have
10 these special Committees set up, the briefs go not only
11 to our own Research Staff, but to those Committees, and
12 then eventually there will be co-operation and conference
13 between the various groups, and then eventually with the
14 Commission itself. The McFarlane Committee will be dealing
15 very specifically with curriculum for instance. It will
16 no doubt be dealing with the question of methods of teach-
17 ing, and such things as whether a recommendation that was
18 strongly put to us in Winnipeg by two general practitioners,
19 that there should be a Chair of General Practice established
20 in the medical schools in Canada, and so as to general
21 practice in a sense out of the same condition that Dr. Co-
22 burn referred to, the idea of the psychiatrists, to bring
23 them on the same level in public opinion so far as recruit-
24 ment is concerned, and everything else.

25 ~~and points~~ We would be very pleased to have any comments
26 from any of you gentlemen on any of these points. They
27 will be recorded and passed on to Dr. McFarlane.

28 ~~it is~~ DR. MILLER: Probably a point of emphasis.
29 We would hope that the prestige shall we say, of this
30 Commission could be brought to bear, in light of the

1 they need, and for them to make recommendations to us,
2 and of course, we are looking for the fullest co-operation
3 as we know we are going to get it, from all the medical
4 schools in Canada to Dr. McFarlane's Project Committee,
5 because naturally he has to go to the medical colleges for
6 ideas and suggestions and so forth.
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9 Committee is operating are very broad in the sense of
10 medical education, and as with other briefs, where we have
11 these special Committees set up, the briefs go not only
12 to our own Research Staff, but to those Committees, and
13 then eventually there will be co-operation and conference
14 between the various groups, and then eventually with the
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16 very specifically with curriculum for instance. It will
17 no doubt be dealing with the question of methods of teaching,
18 and such things as whether a recommendation that was
19 strongly put to us in Winnipeg by two general practitioners
20 that there should be a Chair of General Practice as well as
21 in the medical schools in Canada, and so as to general
22 practice in a sense out of the same condition that Dr. Col-
23 lins referred to, the idea of the psychiatrist, to bring
24 them on the same level in public opinion as far as mental
25 medicine is concerned, and everything else.
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28 from any of you gentlemen on any of these points. They
29 will be recorded and passed on to Dr. McFarlane.
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31 DR. MILLER: Probably a point of emphasis.
32 We would hope that the prestige shall we say, of this
33 Commission could be brought to bear, in light of the



1 financial needs that we proposing, and no doubt other
2 medical schools are proposing. We realize the impediment
3 that the British North America Act sets up in certain
4 respects, and at the same time we are impressed of course,
5 with our own needs. We have attempted to emphasize for
6 instance, the proportion of students that our college
7 serves, other than medical students. We are afraid that
8 we would not want you to go away with the thought that as
9 a medical college we train medical students period. This
10 is far from the truth.

11 I am here to represent the basic science
12 departments, and in the term of medical students the
13 fraction of our yield is approximately one-quarter, yet
14 these other students are all ancillary professions, which
15 are necessary for the health services.

16 We anticipate a considerable growth in the
17 number of these students in the future. Presently we
18 handle in our Department about 500, and we expect it to
19 go up to 800 in the next two years. This means more staff,
20 certainly more space, and consequently more money. We hope
21 that the prestige of this Commission will be brought to
22 bear on this.

23 THE CHAIRMAN: Thank you, Dr. Miller.

RY/ss 24 COMMISSIONER GIRARD: Miss Keeler, there is
25 one point I would like more information on: This is on
26 page 78, paragraph 222. We do have in Canada a large num-
27 ber of nurses prepared in the hospital schools and the
28 three-year courses, and a great deal of these nurses want
29 to go on for further education, and I understand from this
30 paragraph that you have a plan for this group of nurses,

financial needs that we proposing, and no doubt other

that the British North America Act sets up in certain
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THE CHAIRMAN: Thank you, Mr. Miller.

COMMISSIONER D'ARNO: Miss Keeler, there is

one point I would like more information on: this is on
page 78, paragraph 22. We do have in Canada a large num-
ber of nurses prepared in the hospital schools and the
three-year course, and a great deal of these nurses want
to go on for further education, and I understand from the
program that you have a plan for this group of nurses.



1 which is the very important group of nurses in our whole
2 profession: Would you care to elaborate on that plan?
3 PROF. KEELER: Well, the plan is in a bit of
4 a nebulous stage, but we have a lot of experience with
5 nurses coming in from various schools of nursing and stay-
6 ing with us a relatively short time -- seven or eight
7 months; that is, the academic year -- the field work.
8 That is not long enough to move them from where they were
9 to where we would like them to be. Still, we would like
10 to set up a graduate nurse degree program, and probably
11 set it up in stages, because we need a great many nurses
12 with a more exacting preparation than our hospital course
13 give, but we can't expect in the foreseeable future we will
14 have enough come out of straight degree programs. Nor will
15 we have enough graduate nurses with the interest and motiva-
16 tion etcetera to take a degree course on top of the R.N.
17 Still, we would like to set it up in stages so that they
18 can come to use and then go out and work in positions of
19 leadership, instead of going to them at the end of the
20 eight months diploma and saying, "You are all polished up",
21 when you realize it is just a step.
22 COMMISSIONER GIRARD: This is what we used
23 to call the patchwork system.
24 PROF. KEELER: Yes, this diploma course.
25 COMMISSIONER GIRARD: And you would like to
26 integrate this in your university program as a whole?
27 PROF. KEELER: Yes, but be able to offer
28 the graduate nurse a program in one year that will be very
29 helpful to her; but it will be a step towards the second
30 year. She can leave it at any stage and then function.



1 which is the very important group of nurses in our whole
2 profession: Would you care to elaborate on that point?
3 PROF. KELLER: Well, the plan is in a bit of
4 a nebulous stage, but we have a lot of experience with
5 nurses coming in from various schools of nursing and stay-
6 ing with us a relatively short time -- seven or eight
7 months; that is, the academic year -- the field work
8 is done in the hospital. We would like them to be. Still, we would like
9 to set up a graduate nurse degree program, and probably
10 set it up in stages, because we need a great many nurses
11 with a more extensive preparation than our hospital course
12 gives, but we can't expect in the foreseeable future we will
13 have enough come out of straight degree programs. Now, will
14 we have enough graduate nurses with the interest and motive
15 then elevates to take a degree course on top of the B.S.
16 Still, we would like to set it up in stages so that they
17 can come to use and then go out and work in positions of
18 leadership, instead of going to them at the end of the
19 eight month diploma and saying, "You are all polished up."
20 when you realize it is just a step.
21 COMMISSIONER GILBERT: That is what we need
22 to call the postwork stage.
23
24 COMMISSIONER GILBERT: And you would like to
25 have this in your university program as a whole?
26 PROF. KELLER: Yes, but we like to offer
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1 We have a great need of nurses over and above the R.N.

2 COMMISSIONER GIRARD: I think it is very
3 interesting you at the university level are doing this and
4 trying to look after university students who you have
5 developed. This is a plan to integrate this group which,
6 as I say, is a group which is an important group -- our
7 hospital school graduates, and you have a plan to incorpor-
8 ate their future educational needs in your degree program.

9 PROF. KEELER: Yes.

10 COMMISSIONER GIRARD: Could I ask you on
11 what basis you have the criteria of one degree nurse to
12 four -- it is on page 75.

13 PROF. KEELER: We have four thousand regis-
14 tered nurses in the Province. We have about four hundred
15 and odd positions requiring preparation more than an R.N.
16 So, I divided it, and that would be one nurse with more
17 preparation; we say one year is not enough, still we say
18 that we need a degree course.

19 THE CHAIRMAN: Those are actual positions?

20 PROF. KEELER: Those are actual positions
21 we have in the Province as of April, 1961, when we did a
22 rather major study of nursing in the Province: 4000
23 registered nurses, 480-odd positions requiring a more
24 exacting preparation than R.N. So, we really need one to
25 four.

26 COMMISSIONER GIRARD: You outline here a
27 study that I realize would be of very great help if it
28 could be done, and you have gone so far as to estimate the
29 cost?

30 PROF. KEELER: Yes.



1 COMMISSIONER GIRARD: Then, I take it from
2 the bottom of page 8 that the Canadian Conference of Univer-
3 sity Schools of Nursing are interested in working out some
4 of the studies: Do you know for sure if the Canadian
5 Council of University Schools of Nursing are going to
6 present a Brief, or are going to make this suggestion to
7 us later on?

8 PROF. KEELER: They are going to present a
9 Brief, I believe, in the Spring, and the Canadian Conference
10 of University Schools of Nursing is an organization which
11 has a potential for a contribution, but it has never been
12 able to make this contribution. It has been in existence
13 for a considerable number of years -- I think almost twenty --
14 I am not sure. However, they need help, and they have
15 tremendous potential, and if we could say to the Conference
16 "We have a beautiful little study: Can you help us?",
17 we would appreciate that very much.

18 COMMISSIONER GIRARD: You mean for them to
19 help you do it, or could they do it -- could it be turned
20 over to them if you couldn't do it?

21 PROF. KEELER: Yes, or give us the money.

22 COMMISSIONER GIRARD: Well, thank you very
23 much.

24 COMMISSIONER FIRESTONE: Dr. Begg, on page
25 7 and the top of page 8 of your submission to the Thompson
26 Committee, you say there are 126 students in the four
27 medical years, 1960-1961. How many students are in the
28 first medical year?

29 DR. BEGG: We have forty vacancies in first
30 year medicine.



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4 of the studies: Do you know for sure if the Canadian
5 Council of University Schools of Nursing are going to
6 present a Brief, or are going to make this suggestion to
7 us later on?
8
9 PROF. KREMER: They are going to present a
10 Brief, I believe, in the Spring, and the Canadian Conference
11 of University Schools of Nursing is an organization which
12 has a long history of presenting such suggestions.
13 for a considerable number of years -- I think since twenty
14 I am not sure. However, they need help, and they have
15 tremendous potential, and if we could say to the Committee
16 "We have a beautiful little study: Can you help us?",
17 we would appreciate that very much.
18 COMMISSIONER GILKIN: You mean for them to
19 help you do it, or could they do it -- could it be turned
20 over to them if you couldn't do it?
21 PROF. KREMER: Yes, or give us the money.
22 COMMISSIONER GILKIN: Well, thank you very
23 much.
24 COMMISSIONER FLETCHER: Dr. Barry, on page
25 7 and the top of page 8 of your submission to the Thompson
26 Committee, you say there are 125 students in the four
27 medical years, 1950-1951. How many students are in the
28
29 DR. EMGO: We have forty vacancies in 1950



1 COMMISSIONER FIRESTONE: You have forty
2 vacancies: Are all forty filled?

3 DR. BEGG: Yes, sir.

4 COMMISSIONER FIRESTONE: Have you had more
5 applications of bright students -- students who you would
6 consider qualified, than you can place?

7 DR. BEGG: I warned the Chairman that I am a
8 twenty-five day old Dean, so if some of my answers are a
9 little hesitant, you will understand. The truth of the
10 matter is, sir, we do have difficulty filling our first
11 year class with the calibre of student we would like. We
12 don't have a large enough selection. Many schools tried
13 to experiment for a year or two by lowering their standards,
14 and this was universally disastrous. We have ten percent --
15 that is, four -- set aside for people outside the Province.
16 This year we have good selection because there are a great
17 number of applicants. I would say at the moment we are
18 just getting enough of the type of students we want. If
19 we really raise the standard to where we would like it,
20 then, not enough.

21 COMMISSIONER FIRESTONE: How many of the
22 forty would graduate -- and please feel free to call on
23 your colleagues.

24 DR. BAILEY: If I remember correctly, there
25 is a wastage of somewhere between ten and fifteen percent
26 on a class.

27 DR. MILLAR: Ten to twenty percent per year.

28 DR. BAILEY: Yes; in the first two years,
29 particularly.

30 COMMISSIONER FIRESTONE: I have worked this

Have you had more

applications of bright students -- students who you wish

to take courses, then you can place

little better, you will understand. The origin of the

matter is, and we are all of us, I think, our first

year class was the subject of a study we were like. We

don't have a large class section. Many schools have

to experiment now a year or two, lowering their standards

and this was naturally a mistake. We have ten percent

that is, I am not sure for people outside the Province

This year we have had to look for people there and a class

number of applications. I would say to the women we are

just getting a rough idea of the type of students we want. If

we really want to know what we want we should find it

then, not enough.

COMMISSIONER F. WESTON: How many of the

forty would graduate and how many would leave school on

Dr. BALLY: It is impossible to say, in

is a waste of time and money and I think percent

on a class.

Dr. MILLER: Ten to twenty percent per year

Dr. BALLY: Yes, in the first two years.

partially.

COMMISSIONER F. WESTON: I have worked



1 out based on the submission which you have made, and you
2 say that the four graduating classes, 1957-1960, have
3 yielded 128 physicians with M.D. (Sask.) degrees. That
4 would work out to about thirty-two per year, and if you
5 had forty in your classes it would be a wastage of twenty
6 percent. This is very approximate, because you may not
7 always have had forty.

8 DR. BEGG: That is quite correct; we did
9 not always have forty.

10 COMMISSIONER FIRESTONE: Roughly speaking,
11 the forty students of yours may yield you thirty-two or
12 thirty-four graduates per year of whom on an average four
13 are foreign students, and it would leave you about thirty
14 graduates that are Canadian; is that approximately correct?

15 DR. BEGG: Yes.

16 COMMISSIONER FIRESTONE: Allowing for the
17 fact that some of the graduates might move to other parts
18 of Canada, would that perhaps not indicate that you only
19 have something like twenty or so that may actually practice
20 medicine in the Province of Saskatchewan?

21 DR. BEGG: Mr. Macleod reported to the
22 Senate in November 1961, on the activity and locations of
23 one hundred and nine graduates. For example, our graduates
24 last year are all doing their internships, so they have
25 been deleted. Of the 109 -- and this is relevant to the
26 Chairman's question on general practice -- seventy of these
27 109 are in general practice; forty-five are in Saskatchewan
28 twenty in urban and twenty-five in rural. So, actually
29 we have been producing quite a number of general practi-
30 tioners -- roughly 65% of our graduates. About 50%, I



say that the four graduating classes, 1957-1960, have

would work out to about thirty-two per year, and if you
had forty in your classes it would be a wastage of twenty
percent. This is very approximate, because you may not
always have had forty.

DR. BAKER: That is quite correct; we do

not always have forty

the forty students of your day, you might have or
thirty-four graduates per year of whom on an average four
are foreign students, and it would leave you about thirty
graduates that are Canadian; as that approximately compares

DR. BAKER: Yes

COMMISSIONER: Allowing for the

fact that some of the graduates might move to other parts
of Canada, would that perhaps not indicate that you only
have something like twenty or so that are actually practicing
medicine in the Province of Saskatchewan?

DR. BAKER: Yes, that is correct.

Senate in November 1957, on the activity and location of
one hundred and nine graduates. For example, our graduates
last year are all going to be in Saskatchewan, so they have
been deleted. Of the 109 -- and this is relevant to the
Chairman's question on general practice -- seventy of the
109 are in general practice; twenty-five are in hospital
work; in urban and twenty-five in rural. So, actually

Chairman -- roughly 65% of our graduates. About 10% I



1 think, of our graduates are doing general practice in
2 Saskatchewan, roughly half in the city and half in the
3 country. Thirty-five of our graduates are still in
4 specialty training; we don't know whether they will end
5 up in Saskatchewan or British Columbia or Ontario or
6 where. Only four are in public health and allied profes-
7 sions. So, it is difficult to be accurate. We know some
8 of the boys presently in general practice will subsequently
9 go into specialty training. Those who are in specialty
10 training may or may not come back to Saskatchewan. But,
11 seventy of 109 of our graduates are at the moment practising
12 in Saskatchewan.

13 COMMISSIONER FIRESTONE: If I can apply this
14 percentage to the thirty graduates that remain with you, or
15 the thirty people you may graduate, you suggest roughly
16 two-thirds are likely to remain in practice here -- I think
17 you mentioned 65% -- and that would be something like
18 twenty remaining in Saskatchewan?

19 THE CHAIRMAN: It could be more, because
20 some of the considerable percentage doing their specialties
21 now might come back.

22 DR. BEGG: Yes.

23 COMMISSIONER FIRESTONE: I accept that, but
24 there may be perhaps two or three that come back.

25 DR. BEGG: On the contrary, some in general
26 practice would take specialties and move away.

27 COMMISSIONER FIRESTONE: Yes, so on balance --
28 and I don't want to tie this down to twenty or twenty-two
29 or eighteen -- but just on average you are likely to be
30 left with something like twenty out of your graduates that



Saskatchewan, roughly half in the city and half in the

country. Thirty-five of our graduates are still in

specialty training; we don't know whether they will end

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sions. So, it is difficult to be accurate. We know some

go into specialty training. Those who are in specialty

training may or may not come back to Saskatchewan. But

seventy of 100 of our graduates are at the moment practicing

in Saskatchewan.

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the thirty people you may discharge, you suggest roughly

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THE CHAIRMAN: It could be more, because

DR. BROWN: Yes.

COMMISSIONER FIRESTONE: I assume that, but

there may be perhaps two or three that come back.

DR. BROWN: On the contrary, some in general

COMMISSIONER FIRESTONE: Yes, so on balance

and I don't want to tie this down to twenty or twenty-two

or eighteen - but just on average you are likely to be

left with something like twenty out of your graduates that



1 would be practising here for a period of time. Now, there
2 are close to 800 practising physicians in Saskatchewan,
3 and therefore if you train an average of twenty per year,
4 you are adding to the practising physicians in the Province
5 of Saskatchewan at a rate of $2\frac{1}{2}\%$ per annum, and the problem
6 this poses is quite obvious: Is this really a sufficient
7 number, (a) to add sufficient physicians to your stock
8 and allow for future growth -- and I think you probably
9 will say --

10 DR. BEGG: No.

11 COMMISSIONER FIRESTONE: No. Therefore, the
12 question arises --

13 DR. BEGG: No, no.

14 COMMISSIONER FIRESTONE: No, no; very good.
15 Therefore, if the answer is "no, no", you are facing a
16 problem of how you can expand your facilities and train
17 more students here. Have you a suggestion to make to this
18 Commission of how much or what expansion of facilities
19 would be required over the next ten years, for example, to
20 train an adequate number -- a number that will take care of
21 the attrition due to leaving, and to the fact that a grow-
22 ing Saskatchewan needs more physicians?

23 DR. BEGG: There are two things: On page
24 29, table 4, we have made a more detailed projection of
25 our estimated population growth, and have taken into account
26 the factor you mention, both to allow for more people and
27 for a better ratio. We have actually one in a thousand
28 ratio at the moment. Taking into consideration again the
29 attrition rate, our attrition rate is very heavy. In
30 Canada it is 3%, but in Saskatchewan it is 10%. So, we



1 would be practising here for a period of time. Now, there
2 are close to 800 practising physicians in Saskatchewan,
3 and therefore if you train an average of twenty per year,
4 you are adding to the practising physicians in the Province
5 of Saskatchewan at a rate of 2 1/2 per annum, and the problem
6 this poses is quite obvious: Is this really a sufficient
7 number, (a) to add sufficient physicians to your stock
8 and allow for future growth -- and I think you probably
9 will say --

10 DR. BEGG: No.

11
12
13 DR. BEGG: No, no.

14 COMMISSIONER BURNSTON: No, no; very good.

15 Therefore, the answer is "no, no", you are facing a
16 problem of how you can expand your facilities and have
17 more students here. Have you a suggestion to make to this
18 Commission of how much of what expansion of facilities
19 would be required over the next ten years, for example, to
20 train an adequate number -- a number that will take care of
21 the attrition due to leaving, and to the fact that a growing
22 Saskatchewan needs more physicians?

23 A: Well, there are two things: On page

24 20, Table A, we have made a more detailed projection of
25 our estimated population growth, and have taken into account
26 the factor you mention, both to allow for more people and
27 for a better ratio. We have actually one in a thousand
28 left at the moment, taking into consideration again the
29 attrition rate, our attrition rate is very heavy. In
30 Canada it is 35, but in Saskatchewan it is 105. So, we



1 have to have a good number of doctors just to maintain the
2 status quo. By 1980 we will require 169 additional doctors,
3 in that particular year. We feel that with certain adjust-
4 ments --- and we have studied this --- we would like to
5 get up to an incoming class of sixty. This is basically
6 the reason for the request for \$2,000,000.00. It is
7 literally true at the moment you would have great difficul-
8 ty in squeezing one more student into the medical building.
9 Things are stored in the hall; one department cannot expand
10 its graduate training program, and another cannot expand
11 its research program. We don't know where to put the
12 teachers. So, very much one of our priority requirements
13 is the provision of funds to provide space, because it
14 takes several years to provide the space. So, this is
15 certainly one of our major priority problems. The second
16 problem which disturbs us considerably, in the light of
17 previous questions, we are having a modicum of difficulty
18 getting good students for a class of forty: So, what
19 happens for sixty? So, we have to work hard on this prob-
20 lem and we are continuing studies on how we might get more
21 good students. The third thing is the provision of good
22 teachers for the students. So, I think on all fronts
23 we have to get more staff, and I am really more impressed
24 by people than things -- we have to get more staff and
25 more space and more students to do the job which we very
26 much need to do in Saskatchewan. As a matter of fact,
27 this whole preliminary study suggests that we could be in
28 real trouble in Saskatchewan in the very near future --
29 particularly the big thing which we have been depending on --
30 30% of the immigration to take care of our needs, and this



1 is something beyond our control. So, we could be in
2 serious difficulty in Saskatchewan.

3 COMMISSIONER FIRESTONE: The serious dif-
4 ficulty referring to a shortage of practising physicians?

5 DR. BEGG: Yes.

6 COMMISSIONER FIRESTONE: I am very much
7 impressed by your outline of the three basic requirements
8 to achieve what is a desirable objective. I was wondering
9 whether in preparing this Brief and giving some further
10 thought to what your requirements are you have worked out
11 a capital budget and an operating budget and a staff
12 requirement budget to have a medical school for sixty
13 students in your first year of medicine? Have such budgets
14 been worked out and, if so, could they be made available
15 to the Commission in writing?

16 DR. BEGG: Yes. When the studies were done,
17 we were rather unsure. We would be happy, though, to give
18 you our very rough data. We think that the sum of
19 \$2,000,000.00 would take care of our facility requirement.

20 THE CHAIRMAN: Including the extra floor on
21 the cancer research building?

22 DR. BEGG: Yes, sir. We are just in the
23 process of working through the staff requirements. Last
24 June all departments submitted to the President their pro-
25 jections of their staff, space requirements if and when the
26 University reached a total enrollment of 8,000. These
27 are presently being worked on by the forward planning com-
28 mittee, and I would say that within the next few months we
29 would be able to give you more specific data. We need
30 more teachers, and if you take a mean figure on salaries,



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mittee, and I would say that within the next few months we

would be able to give you more specific data. We need 29

more teachers, and if you take a mean figure on salaries,



1 you can get a figure.

2 COMMISSIONER FIRESTONE: You understand if
3 this Commission is to make recommendations to the Federal
4 Government for some financial support, it has to be spelled
5 out in specific terms -- what the money is going to be
6 spent for and what it will achieve, and therefore, we must
7 have some specific programs and what good it will be --
8 not just, "We need \$2,000,000.00", but what it would be
9 used for.

10 DR. BEGG: I think it is fairly well spelled
11 out here.

12 COMMISSIONER FIRESTONE: Yes, but I am think-
13 ing in terms of a rounded program which sets out the
14 capital budget, the operating budget and the staff require-
15 ments, because these are the three essentials. As you
16 suggested yourself, it is not enough to have brick and
3 17 mortar; you have got to have the people, and you must be
18 able to pay their salaries, and expenses. So, if we can
19 get your views in a rounded fashion it will help not only
20 the Commission, but our various study groups. Thank you.

21 COMMISSIONER VAN WART: Dr. Begg, you
22 visualize increasing your classes to sixty: Does that
23 create a residence problem?

24 DR. BEGG: Yes, sir, theoretically, in the
25 sense that at the moment I think we can place some 250 out
26 of 5,000 students in residence now. So, placing twenty
27 more would not create too much of a problem. Universities
28 have expansion programs now where priority is being given
29 to residence and feeding facilities. This is being studied,
30 and the plans are being drawn up at the moment for this.



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to residence and feeding facilities. This is being studied
and the plans are being drawn up at the moment for this.



, AG/SS

1 We do have very inadequate residence facilities at the
2 University now.

3 COMMISSIONER VAN WART: Would you feel some
4 estimate of your requirements should be put in for that
5 phase? You have twenty over four years, that is eighty
6 students extra.

7 DR. BEGG: I quite agree. The University,
8 for instance, at the moment, has 5500 students and hopes
9 or fears in the near future to have some 8,000. The
10 problem at the moment is to provide housing for one-third
11 of the students and I think in reality these eighty more
12 students we might have is going to be a small drop in the
13 bucket in regard to the overall increase. There is no
14 special facilities for the students of medicine, they must
15 bid with the other students as best they can.

16 COM. VAN WART: Lack of better residence
17 facilities would certainly be detrimental in getting a
18 good type of student in your classes.

19 DR. BEGG: That is a fact, yes, sir.

20 COMMISSIONER STRACHAN: I am sure if I ever
21 find time to digest all the reading material before me
22 there will be no questions I can reasonably ask but
23 one that is not perhaps included here; if there is any
24 member of your group working intimately with the internes
25 this year, would you care to express an opinion of their
26 plans regarding remaining in Saskatchewan under the new
27 Health Act?

28 DR. SWANSON: I cannot answer the question
29 specifically as to the internes in residence this year.
30 The figures I can offer the Commission, though, would

University now.

COMMISSIONER VAN HANDEL: Would you feel some

estimate of your requirements should be put in for this

phase? You have twenty over four years, that is agency

students extra.

DR. BAKER: I quite agree. The University

for instance, at the moment, has 100 students and hopes

or fears in the near future to have some 2,000. The

problem at the moment is to provide housing for one-third

of the students and I think in reality these eight years

students we might have in going to be a small drop in the

bucket in regard to the overall treatment. There is no

special facilities for the students of medicine, they have

all with the other students as best they can.

DR. BAKER: I am sure that the

facilities would certainly be better than in the past.

Good type of student in your classes.

DR. BAKER: That is a fact, yes, yes.

COMMISSIONER STANLEY: I am sure it is

find time to digest all the reading material before me

there will be no question of any difficulty at all.

One that is not perhaps included here, it would be a

member of your group working intimately with the University

this year, would you care to express an opinion of the

plans regarding retaining in Germany under the new

Health Act?

DR. STANLEY: I cannot answer the question

specifically as to the income in residence this year.

The figures I can offer the Commission, though, would



1 cover the present, up until the present time since we were
2 in operation in 1955. At the moment registered in this
3 Province for practice there are twenty-seven of our former
4 internes and forty-seven of our residents for a total of
5 seventy-four plus three others who took what we refer to
6 as an administrative residency, so there is a total of
7 seventy-seven who are registered for practice in this
8 Province.

9 COMMISSIONER STRACHAN: That does not exactly
10 answer my question.

11 DR. SWANSON: No, sir, it does not. I can-
12 not answer for this year.

13 COMMISSIONER STRACHAN: I am trying to find
14 out if you have any appreciation of the mental attitude of
15 your future physicians regarding their practice in Saskat-
16 chewan?

17 DR. SWANSON: No, sir, I have not.

18 DR. COBURN: I might speak to that. All I
19 can say in that regard is there is a certain mental dis-
20 quietude amongst the resident staff on the future practice
21 in this Province insofar as the uncertainty which it pro-
22 vides. Any young man in medicine who is a resident quite
23 naturally is looking for security which is a term that the
24 whole population seems to be looking for these days. There-
25 fore, he is more likely to go or look for work in a place
26 where the conditions of work are reasonably certain rather
27 than where the future is uncertain. As to specific numbers
28 and where they are going I am unable to say, but I think
29 that attitude does exist.

30 COMMISSIONER STRACHAN: I am sure you must



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and where they are going I am unable to say, but I think
that attitude does exist.

COMMISSIONER STRACHAN: I am sure you would



1 hear them in discussion and have some idea.

2 DR. COBURN: Yes.

3 DR. BEGG: I wonder if I might speak to
4 this question of general practitioners?

5 THE CHAIRMAN: Yes.

6 DR. BEGG: I think our results show we have
7 been concerned and our philosophy has been not so much that
8 we are training a general practitioner as what we call the
9 basic doctor, a doctor who has the ability to move into
10 general practice, special training, research, administra-
11 tion, all the various sets of medicine. In an attempt to
12 give some consideration to general practitioners there is
13 a compulsory world perceptorship where our student is
14 required to spend two weeks with a selected world perceptor
15 who take the boys into their homes with them. The student
16 follows the practitioner around on all his various activi-
17 ties, social as well as professional to try to get an idea
18 of what the problems are that are faced by the general
19 practitioner and the type of life he leads. This gives our
20 student a much better appreciation of the benefits and
21 joys of a general practitioner as well as the difficulties.
22 We do not have a department of general practice in the
23 faculty of medicine per se, but in the University Hospital
24 we do have a Department of General Practice and there are
25 several of the general practitioners who are attached to
26 the various departments in the hospital. The students
27 come into contact with these gentlemen and through normal
28 education are being taught and have available to them
29 general practitioners who are aware of these problems.
30 Actually I think we are doing quite a bit towards this.

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1 ed. entage THE CHAIRMAN: Thank you. Now, you graduated
2 thirty or thirty-two last and they must go on to an interne-
3 ship of a minimum of one year. Where are they this year?

4 DR. SWANSON: We have seven of this last
5 class.

6 THE CHAIRMAN: How many remained in
7 Saskatchewan?

8 DR. SWANSON: I would have to estimate.
9 I believe there are approximately the same number or a few
10 more at City Hospital so there are at least fourteen in
11 this Province and there may be a few more. That is as far
12 as I can go.

13 THE CHAIRMAN: Can you give any reason why
14 the greater majority do not remain in Saskatchewan to do
15 their interneship?

16 DR. COBURN: I think I would like to jump
17 in here if I may, because I have definite views on this.
18 I think there are several reasons for this and they are
19 not because they do not like working in the hospitals of
20 Saskatchewan. I think it is more of a sociological ques-
21 tion. These lads and lasses, many of them have spent up
22 to six or more years in this University and naturally
23 enough they want to see medicine practised elsewhere, what
24 it is like. There is a tremendous urge to get out of this
25 climate, to go to other schools and see how things are
26 done elsewhere, to go down to the States and see what
27 medicine is like there. Actually I would personally, as
28 a teacher of surgery, strongly encourage this idea. There
29 is nothing worse than getting strongly parochial and as
30 long as they go away and come back, it would be a great



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a teacher of surgery, strongly encourage this idea. There

is nothing worse than getting strongly parochial and as

long as they go away and come back, it would be a great



1 advantage to this Province. As long as we get graduates
2 from other schools across Canada to come here and see how
3 we work, this would be an excellent thing.
4 I think where they take their undergraduate
5 training is a matter of family. Many of these people are
6 married and have children and they therefore do not want
7 to move around. I think it is fair to say that the
8 unmarried members have a tendency to move away and the
9 married ones to stay. Here are the numbers: In 1961 - '62
10 the staff internes in the University Hospital, of the sixty-
11 two, sixteen were from Saskatchewan, seventeen from other
12 provinces, eleven graduates from the United Kingdom and
13 twenty-four from other countries. There are a lot incoming
14 from other countries, as you know. I think those are the
15 reasons behind this.

16 DR. SWANSON: If I may interject here to
17 say my answer was not incorrect when I say from this present
18 class, that includes previous ones.

19 THE CHAIRMAN: Dr. Swanson, are you going
20 to be before us another time?

21 DR. SWANSON: Yes, sir, tomorrow, I believe.

22 THE CHAIRMAN: I have some questions and if
23 you are not coming back we were going to ask them while you
24 are captive here.

25 I am moving into an entirely different
26 field now. It has been strongly recommended in various
27 briefs that there should be a school of dentistry in
28 Saskatchewan. Do you visualize in the foreseeable future
29 in terms of budget and so forth any reasonable possibility
30 that there could be a school of dentistry on the campus at



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that there could be a school of dentistry on the campus as



1 Saskatoon?

2 DR. BEGG: I think, frankly, we have not
3 approached this problem. There is a school in Alberta and
4 there is a new one beginning at Manitoba. You are probably
5 aware of the fact that the four western presidents actually
6 have a meeting every year, an informal get-together, and
7 I think there is an attempt, particularly with the three
8 Prairie Provinces, to share our problems and if one has
9 facility A, then it is rather wasteful for the others to
10 have it. We try to split it up. I would think amongst
11 our dental acquaintances I have not heard any great pres-
12 sure for the formation of a school of dentistry in Saskat-
13 chewan.

14 THE CHAIRMAN: Some of the schools, in any
15 event, perhaps at Dalhousie where the two first years are
16 sort of a common instruction for dentistry and medicine and
17 the dentists were urging that that should be changed in
18 that the school of dentistry should be a complete unit with
19 its own instruction all the way through. If there was a
20 school of dentistry I suppose they would have to accept
21 that proposition. And for a limited period at least it
22 would be an increased load on the school of medicine?

23 DR. BEGG: Yes.

24 DR. MILLAR: In my preparation of the
25 schedule to the President this Summer I inquired into this
26 because I anticipated if a school of dentistry was set up
27 the type of facility was involved. The answer I got was
28 that nothing was in sight at the present time. The reason
29 given was that they did not see their way clear to getting
30 an adequate dental teaching staff. This was one reason



DR. HODG. I think, frankly, we have not

there is a new one beginning at Manitoba. You are probably
aware of the fact that the four western presidents seem to
have a meeting every year, an informal get-together, and
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have it. We try to split it up. I would think amongst
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sents for the formation of a school of dentistry in Saskat-
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THE CHAIRMAN: Some of the schools, in any
event, perhaps at Dalhousie where the two first years are
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the dentists were right that this should be changed in
that the school of dentistry should be a complete unit with
that proposition. And for a limited period at least it
would be an increased load on the school of medicine.

DR. HODG. Yes.

DR. MILLER: In my preparation of the



1 which seemed to be the chief reason for the absence -- one
2 of the reasons anyway.

3 THE CHAIRMAN: Do you have financial assis-
4 tance for the students? I assume that there are some forms
5 of assistance? The question has been brought forward a
6 number of times that the imposing of conditions to loans
7 or bursaries or financial help appears to be a detriment to
8 the acceptance of a loan or a bursary by the student. Would
9 any of you like to say something in that respect?

10 DR. COBURN: Mr. Chairman, there is one
11 thing there I would like to speak to, and that is rather
12 than loans, bursaries and so forth, I would like to see an
13 increase of scholarships. This is something that in New
14 Zealand where I come from I had experience with whereby a
15 man with academic competence would sit actually on an
16 examination and could obtain a scholarship which would
17 put him through medicine completely. We had a junior and
18 senior university scholarship by which we got our fees
19 automatically paid by holding this scholarship and also a
20 generous board allowance so you had your board covered as
21 well. Literally, if you were of academic competence
22 you could put yourself through medicine for nothing.

23 I feel strongly the encouraging of this type
24 of assistance is valuable. I am not suggesting that bur-
25 saries and so forth are not necessary, but I do think that
26 this would encourage your really top-flight students. We
27 actually had two scholarships, you would sit one to enter
28 medicine and after two or three years you could sit a
29 senior scholarship which would be an indication of the
30 academic performance of the student as he goes through.



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23 actually had two scholarships, you would sit one to enter
24 medicine and after two or three years you could sit a
25 senior scholarship which would be an indication of the
26 academic performance of the student as he goes through.



1 I think this has a degree of stimulus and a certain number
2 of these would be of tremendous value.

3 COMMISSIONER BALTZAN: I wonder if we could
4 have that in written form so that we could have your com-
5 plete proposal of the scholarship scheme?

6 DR. BEGG: There are two points. At the
7 moment only one-tenth of our students have funds available
8 for scholarships and it works out on the average this one-
9 tenth could be \$173.33 in the course of four years.
10 Contrary-wise 50% of our students borrow, on the average,
11 \$1,317.00 from University sources. We have no idea of
12 the money they borrow from their family or otherwise. The
13 average student today has incurred considerable debt by
14 the time he is graduated.

15 The second point, I attended a meeting in
16 Toronto on Monday concerning a brief from the Association
17 of Medical Colleges and they will be dealing in extenso on
18 this, and you will get more information from them. As you
19 are aware, we have not gone into some of these things in
20 depth realizing they would be doing it.

21 COMMISSIONER BALTZAN: If your faculty were
22 in favour of the sort of proposal that has been put before
23 us, how much would be involved, how many scholarships? Just
24 a statement of what your recommendations would be following
25 up the information given to us a minute ago?

26 THE CHAIRMAN: And the needs of Saskatchewan.

27 COMMISSIONER BALTZAN: Exactly.

28 DR. BEGG: Dr. Bagley who has done this
29 particular study, I was talking to him yesterday and he is
30 now beginning a study more extensive on financial aid to



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1 students.

2 DR. COBURN: In that regard there are some
3 items of cost to a medical student per annum. I have
4 worked it out as first, second, third and fourth year and
5 it is estimated that roughly it costs a student \$1,500.00
6 a year to go through medicine. This includes room and
7 board at the modest sum of \$65.00 a month; fees of \$400.00,
8 books of \$75.00, instruments \$160.00 and incidentals and
9 so on \$300.00. That is a very rough estimate. Therefore,
10 the scholarship should be worth, I suggest, \$1,500.00.

11 on the teaching DR. BEGG: There are two matters I would
12 like to comment on briefly. One is a question of the train-
13 ing of technicians. I think with the modern methodology
14 in medicine, we are going to require more and more highly
15 trained and qualified technicians and we are concerned
16 about that.

17 remarks, we are The second matter is we are quite concerned
18 about what has been called continuing medical education
19 and this should not apply only to doctors, but apply equal-
20 ly to the nurses, to the technicians and others. I think
21 unless we have a good continuing education we will not
22 ensure a good performance and maintenance on a continuing
23 basis. We hope in your various functions you will get
24 considerable information on these two subjects.

25 The Chairman. COMMISSIONER BALTZAN: Dr. Begg, the medical
26 school is known to have introduced a very commendable
27 feature, would you be good enough to place on record the
28 number of general practitioners who are on the teaching
29 faculty?

30 THE CHAIRMAN: That is a different figure



In that regard there are some items of cost to a medical student per annum. I have worked it out as first, second, third and fourth year and it is estimated that roughly it costs a student \$1,500.00 a year to go through medicine. This includes room and board at the modest sum of \$65.00 a month; fees of \$100.00 books of \$75.00, instruments \$150.00 and incidentals and so on \$500.00. That is a very rough estimate. Therefore, the scholarship should be worth, I suggest, \$1,500.00. Dr. Bagg: There are two matters I would

like to comment on briefly. One is a question of the training of technicians. I think with the modern methodology in medicine, we are going to require more and more highly trained and qualified technicians and we are concerned about that.

The second matter is we are quite concerned about what has been called continuing medical education and this should not apply only to doctors, but apply equally to the nurses, to the technicians and others. I think unless we have a good continuing education we will not ensure a good performance and maintenance on a continuing basis. We hope in your various functions you will get considerable information on these two subjects.

COMMISSIONER BALTIAN: Dr. Bagg, the medical school is known to have introduced a very considerable feature, would you be good enough to place on record the number of general practitioners who are on the teaching

THE CHAIRMAN: That is a different figure



1 from that given by Dr. Swanson?

2 DR. SWANSON: Twenty-three is the number
3 on our hospital staff.

4 DR. BEGG: I remember quite clearly the
5 figure for the rural participation. There are seventeen.
6 These, I believe, are not automatically on the university
7 staff. It is table 1, page 53. The general practitioners
8 are sixteen.

9 COMMISSIONER BALTZAN: Some areas have
10 raised the question why there are not general practitioners
11 on the teaching staff, and you have a very good representa-
12 tion.

13 THE CHAIRMAN: Well, Dean Begg, gentlemen,
14 and Miss Keeler, we appreciate the thought and time that
15 went into your Brief and the previous Brief which has been
16 made available. And, as I said at the beginning of my
17 remarks, we are relying very heavily on the special pro-
18 ject study for the Commission undertaken by Dr. McFarlane,
19 and I am sure that you will be hearing quite a lot from
20 that Committee during the next few months, and we know that
21 you will be giving that Committee the same kind of co-
22 operation that you have given us here today, and we want
23 to express our thanks for you being here today, and your
24 Brief, and for the help that we are sure we will get in
25 the future. Thank you very much.

26 DR. BEGG: Thank you for hearing us, sir.

27 THE CHAIRMAN: We are going to recess now
28 until two o'clock, when we will hear the representation of
29 the School of Home Economics, followed by the Saskatoon
30 Board of Trade.
--- Luncheon Adjournment.



DR. SWANSON: Twenty-three is the number

DR. BEGG: I remember quite clearly the

figures for the rural participation. There are seventeen. These, I believe, are not automatically on the university staff. It is table 1, page 33. The general practitioners are sixteen.

raised the question why there are not general practitioners on the teaching staff, and you have a very good representation from

THE CHAIRMAN: Well, from Dr. Beeg, gentlemen,

and Miss Keeler, we appreciate the thought and time that went into your study and the provision which has been made available. And, as I said at the beginning of my

remarks, we are giving very heavily on the special project study, not the commission undertaken by the National

and I am sure that you will be hearing quite a lot from that committee during the next few months, and we know that you will be giving that committee the same kind of co-operation that you have given us here today, and we want

to express our thanks for you being in the room, and your brief, and for the help that we are sure we will get in the future. Thank you very much.

DR. BEGG: Thank you for hearing me, sir.

THE CHAIRMAN: We are going to recess now

until two o'clock, when we will hear the representation of the School of Home Economics, followed by the 23rd session



1 ---On resuming at 2:00 P.M.

2 THE CHAIRMAN: We will now proceed with
3 the submission of the College of Home Economics of the
4 University of Saskatchewan. Doctor Hunt?

5
6 S U B M I S S I O N O F
7 THE COLLEGE OF HOME ECONOMICS, UNIVERSITY OF
8 S A S K A T C H E W A N

9 APPEARANCES:

10 MISS E.C. ROWLES, M.Sc., Ed. D., Associate Professor(Foods)
11 MISS H.H. HUNT, M.Sc., Ph.D., Dean and Professor(Nutrition)

12 MISS HUNT: In preparing this Brief the
13 Home Economics members of our Faculty being concerned with
14 various influences that had to do with the members of the
15 family, which is the basic unit of our society, felt that
16 as this Commission heard submissions from various groups
17 across the country, you perhaps would not have your atten-
18 tion drawn to some of the things that were our concern in
19 maintaining and promoting the health of the healthy, and
20 as I have read reports of the briefs that were presented
21 to you previously as coming out in our newspapers, it
22 appears that many of the submissions have been concerned
23 with curing the sick, and I wouldn't quarrel with that.

24 One group of our qualified home economists
25 are directly concerned with therapeutic treatment of the
26 sick, the dietitians, and that group obviously would be
27 included in any discussion of medical services, and a fact
28 that is not always recognized is that many dietitians,
29 qualified, are concerned with feeding the well. We need to
30



SESSION

THE COLLEGE OF HOME ECONOMICS, UNIVERSITY OF

ALASKA STATE COLLEGE

Home Economics members of our Faculty being concerned with various influences that tend to do with the members of the family, which is the basic unit of our society. I feel that as this organization heard information from various groups across the country, you perhaps would not have your attention drawn to some of the things that were our concern in maintaining and promoting the health of the body, and as I have read reports of the health that were presented to you previously as coming out in our newspapers. It appears that many of the adaptations have been concerned with caring the sick, and I wouldn't quarrel with that.

and the dietitians, and that group obviously would be included in any discussion of medical services, and a fact that is not always recognized is that many dietitians.



1 keep the sick alive long enough to get better, and to
2 keep the well alive long enough to look after the sick in
3 the hospitals. I have had great difficulty in getting hold
4 of anybody's budget, because it is not broken down in the
5 form I wish it.

6 A person who is involved in the day to day
7 treatment of the sick is the dietitian, playing a very
8 important part. We had the feeling that the Commission
9 was not aware of the various services the professional
10 home economist played in various roles in the community,
11 so we craved your permission to submit our brief, with the
12 hope that you would have these things in mind as you
13 travelled across the country.

14 I would expect that our National Organizations
15 would be presenting briefs to you speaking for the profes-
16 sion as a whole. However, because we felt that items would
17 not be presented to your attention in the same way, we
18 presented our Brief.

19 Is it your wish that we go over the recom-
20 mendations one by one, or that we answer your questions?

21 THE CHAIRMAN: I think that if you wish to
22 summarize, and take your recommendations one by one. It has
23 been the format, and it seems to have worked quite well.

24 MISS HUNT:

25 This group recommends:

26 1. That the Commission encourage establishment of funds,
27 to be available for post-graduate education of:

28 Dietitians

29 Nutritionists

30 Home Economics extension workers
Home Economics teachers at all levels



1 And we have in mind not only a more satis-
2 factory level of remuneration for the graduates doing their
3 term, which means five years, but especially for university
4 home economics faculty members.

5 THE CHAIRMAN: Five years from what level?

6 MISS HUNT: From high school, and entrance
7 requirements are common for the University. Our University
8 is senior matriculation, so it is a five-year course before
9 the dietitian is qualified to practice under the Provincial
10 Act, and most of the provinces have Provincial Acts.

11 We had in mind in this particular section
12 not only that type of thing, but some national funds to
13 which these people who were doing a job could apply for
14 financial assistance.

15 Universities in theory get sabbaticals, and
16 others because of the scarcity of qualified people to take
17 care of the various responsibilities across Canada, may
18 not have anybody to leave on the job. They may not have
19 any funds to allow them to go away for three months. The
20 theory of doctors visiting several hospitals, as they used
21 to do, and see their various colleagues in a different
22 situation doing the same kind of thing. It may be a case
23 where the home economist applied to a fund for a grant to
24 support them for three or six months while they were off
25 furthering their efficiency in a particular area, and
26 there are not many funds to which the home economist can
27 apply and get a good hearing.

28 THE CHAIRMAN: Are there some?

29 MISS HUNT: Well, not that I can think of
30 at the moment. There are no established funds that are



1 particularly interested in promoting the further qualifica-
2 tion of any of these groups of home economists, and cer-
3 tainly university staffs are pretty well stretched, and it
4 is hard to find a person that qualifies, and if they could
5 get a little support, especially for home economics faculty
6 members, if you could establish a brief leave, maybe not
7 a sabbatical leave, and to be free to go and visit the
8 other universities, again the equivalent of what used
9 to be called walking the hospitals for the doctors. This
10 might support further studies, and doing all sorts of
11 things that would improve the efficiency, but as far as I
12 know, in Canada it is pretty difficult to get any kind of
13 a grant from a fund of that sort.

14 I might say we have had a project in mind
15 for some six years, and we have been unable to find anybody
16 to support it. It is the study of the development of home
17 economics as a profession in this century, to see what they
18 have done, where they have come from, where they started,
19 and to try to find out where best the profession could serve
20 the community in the future, and so far there have been no
21 funds available from any source to support this.

22 We feel that in most of the universities
23 the work at the present time has been devoted to the
24 academic background of the new graduate, and that the time
25 has come for a greater diversification of offerings. In
26 many of our universities the students take home economics,
27 students up to a given point, at various universities, and
28 they take the same basic subjects. Most of the specifica-
29 tions are pointed towards those who plan to go into the
30 teaching field, or those who plan to go into the dietetics



1 or food field, and there are few opportunities at the
2 under-graduate level. Consequently this, this may be good
3 or bad, but consequently we would like to see financial
4 support which involves of course, more staff members. It
5 might or might not involve more space in a given building,
6 and it is not our idea that every faculty of home economics
7 should enter every possible specification, but rather that
8 across Canada in suitable areas this university would add
9 to its present offerings another area of specialization, so
10 that for the group in Canada as a whole they might be able
11 to work through at an earlier date.

12 We are quite well aware that as a whole the
13 under-graduates do not enter. We feel that more graduates
14 should be encouraged in home economics, and if we could
15 work it both ways, from the standpoint of more staff, to
16 do more research, and they are not completely involved in
17 an undergraduate teacher program as they are in many
18 teaching universities, and more support given to this would
19 be of great value to Canada as a whole.

20 2. That the Commission encourage universities to develop
21 extend and diversify their home economics programs
22 at undergraduate and graduate level in order to en-
23 courage the development of research programs in
24 schools and colleges of home economics.

25 In point three we have suggested areas in
26 which we do not know enough answers at the present time.
27 We recommend that the Commission consider the need for
28 research grants designated for special projects within the
29 areas of Housing, Nutrition, Diet Therapy, Hospital and
30 other Quantity Food Service Management, Child Development,



1 Management of resources within the home. In general,
2 these grants should be administered through Schools and
3 Colleges of Home Economics so that they will be closely
4 related to the needs of the home and the family.

5 ~~There are many~~ We feel that our group, as perhaps no other
6 group, from the very interests that go into an undergraduate
7 program, are aware of the many conflicts that bear on the
8 members of the family, and if there are people who can
9 help families, who can help families to reach a decision,
10 they may never come to the general practitioner for advice
11 and psychiatric help, because some of these points of
12 conflict seem to an outsider fairly minor, but they are
13 simply the last stress added to various conflicts within
14 the home. Maybe poor housing, too many people in too small
15 a space, due to a number of things, and if research in
16 these various areas was undertaken in a broad form across
17 Canada ---- but specialization within certain areas under-
18 taken in that area, for instance my field is nutrition --
19 I think it is a poor idea at the the present state of
20 university education of home economists for every home
21 economist to lead to a graduate study of home economics in
22 nutrition. Maybe the University of Saskatchewan, when it
23 moves into the graduate field -- even though I would see
24 nothing to stop me doing a piece of research as an indivi-
25 dual faculty member.

26 ~~Our main interest~~ We think that in the main, because we are
27 aware of these various influences on the individuals that
28 make up the family, that at least some of this research
29 should be under the administrative direction of home
30 economists, though it might be co-operative research with



Management of resources within the home. In general, these grants should be administered through schools and colleges of Home Economics so that they will be closely related to the needs of the home and the family.

We feel that our group, as perhaps no other group, from the very interests that go into an undergraduate program, are aware of the many conflicts that bear on the members of the family, and if there are people who can help families, who can help families to reach a decision, they may never come to the general practitioner for advice and psychiatric help, because some of these points of conflict seem to an outsider fairly minor, but they are simply the last stress added to various conflicts within the home. Maybe poor housing, too many people in too small a space, due to a number of things, and if research in these various areas was undertaken in a broad form across Canada --- but specialization within certain areas might be taken in that area, for instance my field is nutrition -- I think it is a poor idea to let the present state of university education of home economists for every home economist to lead to a graduate study of home economics in nutrition. Maybe the University of Saskatchewan, when it moves into the graduate field -- even though I would not be willing to stop at doing a piece of research as an individual faculty member.

We think that in the main, because we are aware of these various influences on the individuals that make up the family, that at least some of this research should be under the administrative direction of home economists, though it might be co-operative research with



1 sociology and a number of groups, architecture if we had
2 a faculty of architecture.

3 In order to avoid dissipation of effort in
4 this research the responsibility for intensive work in
5 given subject matter areas should be assigned to universi-
6 ties or research agencies in relation to resources and
7 special interests at the different universities.

8 That this Commission promote the development of
9 regional Housing Research agencies which would be charged
10 with studying the socio-psychological implications of
11 housing to the end that better housing for all, regardless
12 of economic position, might be evolved.

13 This refers to more than protection from
14 the weather. It refers to, for instance, a study of space,
15 relationships, how does too much togetherness affect a
16 family? The children who cannot go off to some place and
17 get quiet by themselves, and as far as we know there is
18 nothing of this kind available.

19 That the Commission encourage the establish-
20 ment of training courses at suitable regional centres for
21 those non-professional people who are employed or plan to
22 enter employment as administrators and matrons in institu-
23 tional homes for senior citizens and those of all ages who
24 are handicapped. It is suggested that provision should be
25 made for leave, as required, and financial assistance for
26 the individual during the period of the course.

27 This is an activity that does not directly
28 concern us, but carrying the idea of the thing that a home
29 should provide for every individual into the realm of the
30 individuals who do not have a home of their own and must for



a faculty of agriculture.

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24 concern us, but carrying the idea of the thing that a home

25 should provide for every individual into the realm of the



1 very good and sufficient reasons live in a group, we are
2 aware that because of the urgency and so on of a given
3 situation people live there, but they do not have any
4 proper life. This does not necessarily involve home
5 economists, but we are aware of the situation, and are
6 interested in seeing it corrected.

7 That the Commission investigate the need
8 for, and as it is demonstrated, encourage the development
9 of creative educational programs for groups or individuals
10 handicapped by age or physical disability. As required,
11 financial or other types of support should be provided for
12 training programs for those who will become the leaders.

13 This might involve home economists, because
14 there is a vast area in which we are particularly interest-
15 ed in making it possible for handicapped individuals to be
16 at least in part self-sufficient and responsible individuals.

17 That the Commission investigate salaries
18 presently offered to dietitians by the various governmental
19 departments and services and by other employers, in relation
20 to the kind and amount of responsibility carried and as
21 seems desirable recommend more suitable financial rewards
22 for services rendered.

23 We are quite well aware that when the
24 students come to decide on their area of professional
25 activity, and this is at an undergraduate level, only the
26 person who knows beyond the shadow of a doubt that working
27 in the dietetics field is the one thing she wants to do
28 will go ahead without thinking, what salary would I get?
29 Because our girls -- I think the home economics graduate,
30 not only Saskatchewan graduates, want to be self-supporting



Very good and sufficient reasons live in a group, aware that because of the urgency and so on of a given situation people live there, but they do not have any economists, and we are aware of the situation, and are interested in seeing it corrected.

That the Commission investigate the need for, and as to its demonstration, encourage the development of creative educational programs for groups or individuals handicapped by age or physical disability, as required, financial or other types of support should be provided for training programs for those who will become the leaders. This might involve some economic, because

there is a vast area in which we are particularly interested in making it possible for handicapped individuals to be at least in part self-sufficient and responsible individuals. That the Commission investigate assistance presently offered to disabled by the various governmental departments and services and by other employers, in relation to the kind and amount of responsibility carried and as to the desirable recruitment more suitable financial resources for services rendered.

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RY/ss

1 in this day and age, and want to feel they are making
2 reasonable progress in the scale recognized by society,
3 and that is how much money you get. They want in this day
4 and age to feel they are making reasonable progress, and
5 on the basis which is recognized in society, and that is,
6 how much money you get. Consequently, we are well aware
7 that where a girl is hesitating, that she likes this, but
8 where she likes something else equally as well, if the
9 salary awards immediately on graduation seem to be better
10 the one way, or the time before she gets the salary is
11 shorter, then she may go the other way, and this in turn
12 affects the supply of dietitians available for therapeutic
13 treatment of the sick, for public health services, and
14 for supervision of food in a number of public facilities.

15 That with the existing shortage of qualified
16 dietitians in mind, the Commission encourage the establish-
17 ment of training courses for food supervisors. These lay
18 people could then accept supervisory responsibility for
19 food service in small institutions, under the general
20 direction of a dietary consultant. They could also be
21 employed in larger institutions to release the dietitians
22 from certain routine activities which should not but present-
23 ly do require too much of her personal attention.

24 That the Commission investigate the need
25 for and development of a national school lunch program.
26 The objectives of such a program could be stated as the
27 provision of nutritionally adequate noon meals, at minimum
28 costs and the promotion of nutrition teaching by correlating
29 classroom teaching with the development of good food habits.

30 We are not suggesting every school should



in this day and age, and want to feel they are making
reasonable progress in the scale recognized by society.
on the basis which is recognized in society, and that is,
how much money you get. Consequently, we are well aware
that where a girl is hesitating, that she likes this, but
where she likes something else equally as well, if the
salary awards immediately on graduation seem to be better
one way, or the time before she gets the salary in
advance, then she may go the other way, and this in turn
affects the supply of dietitians available for the service
of the sick, for public health services, and
for supervision of food in a number of public institutions.
That with the existing shortage of qualified
dietitians in mind, the Commission encourage the establish-
ment of training centers for food service workers. These may
people could then accept supervisory responsibility for
food service in our institutions, under the general
supervision of a dietary consultant. They could also be
employed in larger institutions to release the dietitians
from certain routine activities which should not and cannot
be required to require too much of her personal attention.
That the Commission have in mind the need
for and development of a national school lunch program.
The co-ordinator of such a program could be asked to see
provision of nutritionally adequate noon meals, at minimum
classroom teaching with the development of good food habits.
We are now suggesting every school should



1 have a school cafeteria, but we wonder very much, and we
2 do not know the answer, about whether with the large school
3 units and composite schools where children are collected
4 by bus and taken to school, what they have to eat at noon,
5 and whether the noon meal plays its real part in the over-
6 all day's nutrition. I suspect too many people have jam
7 sandwiches and a coke.

8 THE CHAIRMAN: Would you perhaps substitute
9 for that free distribution of milk?

10 MISS HUNT: Not necessarily. I think that
11 would depend on the local situation, but I may encourage
12 them to bring milk from home. I have a recent report that
13 came to me via the Canadian Council on Nutrition on School
14 Milk in Canada, and it was prepared by the Department of
15 Agriculture, by Dr. Drayton, to a meeting in the Department
16 of Agriculture and they were studying school milk, and
17 they studied it intensively in several of the large cities
18 such as Windsor, Montreal, and so on, where there were
19 programs, and the whole conclusion out of this is that
20 milk is a good thing briefly for the people who drink it,
21 but they don't effectively produce any milk program by
22 giving it to youngsters at their age levels in the middle
23 of the morning, or at the recess, or at lunch to meet this
24 need for the between breakfast and dinner type of food
25 intake. The final conclusion in this case is:

26 "From the foregoing it is evident that many
27 Canadian school children have inadequate diets and low
28 milk intakes as compared with what nutritionists recommend.
29 In view of this there are possibilities of school milk
30 programs contributing to the health of the Canadian



1 population through improving the diet of children.
2 To do so they have to be effective in reaching those
3 with inadequate diets."

4 There was no proof in this that the people
5 who needed the milk the most were the ones that bothered
6 to get it.

7 THE CHAIRMAN: Well, suppose it was free
8 milk?

9 MISS HUNT: They have tried various things
10 and not all the children get it, as came out in this report.
11 Now when you asked me whether I would suggest school milk,
12 I would suggest it as part of a general lunch program, but
13 I don't know that distributing free milk, that they would
14 all take it. We have got something like 1.3 ounces in
15 some areas as it averaged out for the children at the
16 school. A lot of the youngsters didn't take any milk even
17 if it was a subsidized program. So, maybe they got half a
18 pint for five cents or something of that sort. These were
19 the things we had in mind in this last recommendation, and
20 it is a situation that needs attention, and it needs atten-
21 tion in various o f the large cities -- maybe as is
22 presently done there in public school cafeterias in some
23 of the larger centres. In some of the other areas maybe
24 they don't. But if the youngsters are carrying lunch,
25 who supervises it? Who encourages them to bring the proper
26 lunch? Bread and jam are fine, as far as they go, but they
27 don't go far enough. This does happen in various areas.
28 School nurses sometimes pick it up, but not unless the
29 child is referred to the school nurse can she do this.

30 MISS ROWLES: Mr. Chairman and Members of



1 the Commission, I would like to just go back to two of the
2 items that Dr. Hunt has referred to. Item three on page
3 13, the need for research. We have the Saskatchewan Re-
4 search Council providing research funds to our college for
5 work in the area on food research. We find we are very
6 much handicapped in doing such work in that we don't have
7 the physical facilities and know what our conditions are
8 as far as building is concerned. So, we can manage to do
9 research during the Summer when the students are away, but
10 not during the Winter months. But, we need greater
11 facilities in our physical setup in order to do research.
12 That whole picture needs to be looked at.

13 Turning to page 11 in referring to our need
14 for research we have something on item 26 that perhaps is
15 not mentioned on page 13, that home economists are continu-
16 ally faced with problems for which research has not yet
17 provided answers, and under these various things we have
18 mentioned the special needs of the handicapped home-maker,
19 and I would like at this time to refer particularly to the
20 needs of the handicapped home-maker and respectfully draw
21 your attention to the developments that are happening here
22 in Saskatchewan. The Department of Public Health in
23 Saskatchewan has just recently appointed a rehabilitation
24 home economist, and I believe it is the first time such a
25 thing has happened in Canada. This home economist is also
26 trained in occupational therapy, and she is prepared to
27 work particularly with home-makers and in looking at the
28 need for such a person there was an estimate made, based
29 on the latest census figures available, that in 1959 there
30 were 6,900 handicapped home-makers in Saskatchewan.



1 These home-makers have to continue to do their job, or
2 should continue to do their job, as home-makers. We look
3 at the handicapped person and say, "How can we give them
4 a job vocationally?", and here they have a job that needs
5 to be done, but they need some help. The home economist
6 can contribute a great deal, and is contributing a great
7 deal, where she gets the chance to do this job with the
8 handicapped home-maker, and I would suggest this is just a
9 beginning. The appointment of such a person, one person
10 for all of Saskatchewan --- she could very well work with
11 a staff of other home economists to help service these
12 home-makers-- the others need not be occupational therapists.
13 This, I think, will happen all over Canada. Already
14 Saskatchewan has had correspondence from the United States
15 asking for a job description of this type of thing. They
16 are very interested in this type of thing. There is an
17 opening for the home economist serving handicapped people
18 in this area -- people who would be considered as not the
19 well people. So, I would like to add to Dean Hunt's
20 suggestion that we are short of home economists, and we
21 need the support of this Commission to understand why home
22 economists can contribute to society. So, in making your
23 recommendations for facilities in various other ways ---
24 physical facilities, facilities for extra training for
25 professional people, and so on -- we hope that you will
26 not overlook the contribution that the home economist
27 makes in this area of health.

28 COMMISSIONER BALTZAN: Dr. Hunt, just one
29 point, please: I must say I have a little trouble with
30 the name of your faculty -- The Home Economics Faculty.



1 It goes on on page 13 -- you have three large fields, and
2 home economics is one. The (a) part of home economics is
3 Extension workers, and the (b) part of home economics is
4 Teachers; and let us say number 2 is Dietitians who are
5 not necessarily at home, as the name would imply -- Hospital
6 Workers, or Workers in public services; and then there is
7 Nutritionists: Am I right in saying that you refer there
8 to the academic and basic science investigators? In other
9 words, the thing that troubles me again is that the word
10 "home" seems to cover three large independent areas?

11 MISS HUNT: Mr. Chairman, this I would like
12 to point out: The things that home economists are doing
13 for the public family, that is, the community, are the
14 very things that an individual will do for members of her
15 family within the home, and from this interest in the home
16 has then grown our professional service in various areas
17 to groups outside the home. When somebody is sick in your
18 family, somebody carries a tray to them and we hope they
19 eat. Somebody does a variety of things. When somebody is
20 sick and goes to the hospital the dietitian looks after
21 them there, and when we have people working in the
22 nutrition field, as apart from the dietitians, they are
23 usually resource people within some public health service--
24 not necessarily all there -- but they may be, and they are
25 the people to whom your visiting nurses and doctors may
26 come for help, and groups within that health region may
27 come for help on, sometimes, what to buy and also what to
28 eat, but again the public health nutrition of that particu-
29 lar group; but it is an outgrowth from the saying that,
30 Mother tries to see Johnny eats the right thing. So, for

1 It goes on on page 13 -- you have three large lists, a
2 home economists is one. The (a) part of home economists is
3 Extension workers, and the (b) part of home economists is
4 Teachers; and let me say number 2 is Dietitians who are
5 not necessarily at home, as the name would imply -- for
6 workers, or workers in public service; and then there is
7 Nutritionists. Am I right in saying that you refer this
8 to the academic and basic science investigators? In other
9 words, the thing that troubles me again is that the word
10 "home" seems to cover three large independent areas?
11 MISS HUNT: Mr. Chairman, this I would like
12 to point out: The things that home economists are doing
13 for the public family, that is, the community, are the
14 very things that an individual will do for members of his
15 family within the home, and from this interest in the home
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17 to groups outside the home. When somebody is sick in your
18 family, somebody carries a tray to them and we hope they
19 eat. Somebody does a variety of things. When somebody is
20 sick and goes to the hospital the dietitian looks after
21 them there, and when we have people working in the
22 nutrition field, as apart from the dietitians, they are
23 really resource people within some public health service --
24 not necessarily all there -- but they may be, and they are



1 groups one person can sometimes be of service to many
2 people if she can deal with them in groups.

3 COMMISSIONER BALTZAN: Do they follow
4 three separate curricula, or is it all one?

5 MISS HUNT: No, the nutritionists in the
6 main are qualified dietitians -- not always, because there
7 are certain public health nutrition fields in which a
8 qualified home economics teacher dealing through the
9 schools, with a perfectly good nutrition background, may
10 function, because she understands the organization more
11 effectively than a dietitian would. But as I think of
12 nutritionists, people who are resource people, sometimes
13 consultants, and so on, in the nutrition field, I think
14 you will find most of them are qualified dietitians.

15 COMMISSIONER BALTZAN: First?

16 MISS HUNT: First.

17 MISS ROWLES: Mr. Chairman, may I add to
18 this point: The dietitians, the nutritionists, the home
19 economists and the home economics teacher are all graduates
20 of the college of home economics, and in the past this has
21 met our need, but in item number 2 Dr. Hunt pointed out
22 that the Commission encouraged universities to develop and
23 expand diversified home economics programs, and we think
24 we are at the point where our programs that have been
25 growing now -- the first degree program was set up by
26 Toronto in 1902 -- and that we are at the stage where we want
27 to look again at our programs and see if we can be a little
28 bit more specific. As you know, the University of Montreal
29 trains its home economists under the College of Medicine.
30 In other universities it is probably under the College of



people if she can deal with them in groups.

COMMISSIONER: BALTAN: Do they follow

three separate curricula, or is it all one?

MISS HUNT: No, the nutritionists in the

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COMMISSIONER BALTAN: First?

MISS ROWLEY: Mr. Chairman, may I add to

this point? The dietitians, the nutritionists, the home

economists and the farm economics teacher are all graduates

of the college of home economics, and in the past this has

met our need, but in item number 2 Dr. Hunt pointed out

that the Commission encouraged universities to develop and

expand diversified home economics programs, and we think

we are at the point where our programs that have been

growing now -- the first degree program was set up by

Minnesota in 1908 -- and that we are at the stage where we

to look again at our programs and see if we can be a little

bit more specific. As you know, the University of Minnesota

train the home economists under the College of Medicine.



1 Arts, and in some cases under the college of agriculture.
2 We are a college in our own right. So that, one must look
3 again and see whether we could do a better job at the
4 college level in training the dietitian, even as an under-
5 graduate. Should we not be more specialized and, if we
6 have a criticism, perhaps we haven't been specialized
7 enough; but we cannot diversify more with limited faculties,
8 limited physical space. We have to be able to see expan-
9 sion ahead.

10 COMMISSIONER BALTZAN: And you will retain
11 the same name?

12 MISS ROWLES: The name "home economics" has
13 received a great deal of criticism in the past. Some of
14 the principal universities in the United States have had
15 meeting after meeting trying to find a better name and
16 haven't yet.

17 THE CHAIRMAN: Thank you very much, Dr.
18 Hunt and Miss Rowles. The recommendations which you have
19 made as well as the Brief you have submitted will be
20 studied by our research group and will receive the conside-
21 ration of the Commission all in due course in preparation
22 of the final report. Thank you very much.

23

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SUBMISSION OF
THE SASKATOON BOARD OF TRADE

APPEARANCES:

MR. C.T. HAZEN

MR. J.S. WOODWARD

MR. A. TUBBY

MR. F. MATHESON

---EXHIBIT NO. 102:

Brief of the Saskatoon
Board of Trade.

MR. HAZEN: Mr. Chairman, may I say in

commencing that in this Brief we emphasize four main points,
namely, the maintenance of freedom of choice for Canadian
people, and care for three groups of Canadian citizens who
we feel are sadly neglected in the field of medical care:
The mentally ill, the chronically ill, and the aged.

If I may read this, Mr. Chairman, it is not
a very long presentation and I think in this way we will
cover all of the essential points.

1. The Saskatoon Board of Trade welcomes this
opportunity of presenting its view to this Royal Commission
on Health. The Saskatoon Board of Trade comprises some
930 paid up members and can be said to represent the com-
mercial, industrial and professional interests of the City
of Saskatoon. Inasmuch as representatives of the Rural
Municipality of Cory sit on the council of the Board, it
may also be said to reflect the views of the farming com-
munity immediately adjacent to the City.

2. The Saskatoon Board of Trade firmly believes
that the destiny of Canada and development of the finest



1 attributes of nationhood can only be developed in an
2 atmosphere of political and personal freedom. We believe
3 that progress depends on the preservation for each indivi-
4 dual of freedom of choice, - of fostering and developing
5 personal initiative - and willing acceptance by all of
6 the rewards, spiritual as well as material, that accrue to
7 the industrious, the clever, the self-reliant. And we
8 believe that in this atmosphere the Canadian Citizen will
9 continue to develop that essential sense of responsibility
10 to himself, his family and his country that has character-
11 ized our great nation through-out its history.

12 3. ~~... ..~~ We believe that reliance on the government
13 for aid, for direction, for security (and as some would
14 wish, to be cared for even from the cradle to the grave)
15 destroys initiative, will power and ambition and will
16 inevitably lead us to the complete subjugation of individual
17 liberty.

18 4. In short Mr. Chairman and gentlemen, we
19 believe in Canada and are doing all in our power to enhance
20 and preserve its greatness.

21 5. ~~... ..~~ In considering our approach to the subject
22 of your enquiry the Board of Trade felt that the whole
23 field of medical care should be approached from a twofold
24 standpoint, namely the economic and the humanitarian aspects.
25 To a large degree these two are inextricably interwoven.
26 If any segment of the community is for economic reasons
27 compelled to deprive itself of adequate medical care and
28 attention, whether through financial inability or deficien-
29 cies in existing governmental medical care programs, the
30 reaction on the economic life of the community is obvious



1 and apparent. We propose to elaborate on this aspect of
2 the situation as we see it, with particular emphasis on
3 the conditions in Saskatoon and district, with which we are
4 familiar and with which we are mainly concerned.

5 6. It should be emphasized that in this presen-
6 tation the Board of Trade is speaking only for its members.
7 But we would judge from press reports of your hearings in
8 other parts of Canada that the situation we underline here
9 exists not only in Saskatoon, but probably through-out the
10 whole of Canada. We have conferred with certain individuals
11 whom we considered qualified, in order to get as much
12 factual background as we felt desirable so as properly to
13 establish the facts on which this presentation is based;
14 and such statements as are contained herein are believed
15 by the Board to be factual and capable of substantiation.
16 May we add here that the Board has given close study to
17 local hospital problems over a period of several years.

18 7. In considering the needs of the citizens of
19 Saskatchewan, and this of course comprises those of immediate
20 concern to the Saskatoon Board of Trade, we have recognized
21 the fact that the ultimate desideratum is that all citizens
22 should have available the best medical care, in the widest
23 possible sense, that modern science can provide.

24 8. We feel, therefore, that to accomplish this
25 properly, consideration must be given to the order of
26 immediate needs of certain sections of the community. We
27 feel that government assistance and care should be directed
28 only to those who are unable to help themselves, to the
29 indigent, the aged, mentally and chronically ill and to
30 those who suffer catastrophic medical expense. It is

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establish the facts on which this presentation is based;
and such individuals as are mentioned herein are believed
by the Board to be factual and capable of substantiation.
We also note that the Board has given close study to
these medical problems over a period of several years.

In considering the needs of the citizens of
Saskatoon, and this of course comprises those of immediate
concern to the Saskatoon Board of Trade, we have recognized
the fact that the ultimate desideratum is the well citizen
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possible sense, that modern science can provide.

We feel, therefore, that to accomplish this
primary, consideration must be given to the order of
the needs of various sections of the community. We
feel that government assistance and care should be directed
only to those who are unable to help themselves, to the
infant, the aged, mentally and chronically ill and to
those who suffer catastrophic medical expense. It is



imperative that the urgent needs of proper, indeed one might almost say minimum care, for the aged, mentally and chronically ill segments of the population should receive prior consideration. After all some 60 to 70 percent of the people of the province are at present covered by medical care plans of one form or another. Those not so covered do so either because they feel they can adequately take care of their own medical needs, or because they are economically incapable of doing so.

For the aged and mentally or chronically ill, there is a wide need for increased and improved services, both in the field of increased facilities at existing hospitals and also for improved services in the way of nursing and professional or semi-professional care. Studies showing the needs of such services are referred to later in this submission.

MENTALLY ILL

10. In our opinion, Saskatoon and probably all of Canada, lacks adequate care for its mentally sick who fare badly compared to the physically ill. Yet, with insufficient funds and proper planning, psychiatric care in Saskatoon could be brought up to a suitable standard.

We will deal with:

(1) The deficiencies in mental health care in Saskatoon today

(2) The steps we believe required to improve this situation.

11. Deficiencies in Psychiatric Care in Saskatoon

Most authorities agree that between 20 and 30 percent of all patients consulting the family doctor do so because of emotional difficulties. To meet this

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11. Deficiencies in Psychiatric Care in Saskatoon
Most authorities agree that between 2 and
30 percent of all patients consulting the family doctor do
so because of emotional difficulties. To meet this



1 important medical problem, the family doctor receives
2 little help from others. Although the MacNeill Clinic
3 provides an exceptionally fine treatment service for child
4 and family problems, it needs more psychiatrists to cope
5 with adult referrals. If patients are to get good care
6 for emotional troubles, the family doctor needs more
7 support.

8 12. The General Practitioner cannot now admit
9 nor treat his mentally sick patients in Saskatoon's
10 hospitals. When hospital care becomes necessary, he must
11 turn over his patients to specialists either at the
12 University Hospital or the Saskatchewan Hospital, North
13 Battleford. Since the University Hospital's 40 psychiatric
14 beds are almost always full, most of these patients must
15 go to the Mental Hospital.

16 13. In 1960, 138 Saskatoon residents were ad-
17 mitted to the North Battleford Provincial Mental Hospital.
18 The average daily number of Saskatoon patients in this
19 institution is about 300. As there is a general reluctance
20 on the part of relatives to commit patients to large
21 mental hospitals, it is reasonable to assume that many
22 needing psychiatric treatment in hospital were denied this.

23 14. Admission to a distant mental hospital has
24 many disadvantages. The patient: (a) is far from home

25 (b) is separated from his family
26 doctor

27 (c) suffers from the stigma associated
28 with a mental hospital

29 (d) receives a lower standard of hos-
30 pital care - for example the daily
cost per patient in Provincial
Mental Hospitals is about one-
quarter that of a patient in a
general hospital.



important medical problem, the family doctor receives little help from others. The family doctor provides an exceptionally fine treatment service for child with adult patients. If patients are to get good care for emotional troubles, the family doctor needs more support.

When hospital care becomes necessary, he must turn over his patients to specialists either at the hospital. Since the University Hospital's 40 psychiatric beds are almost always full, most of these patients must go to the Mental Hospital.

In 1950, 178 Saskatoon residents were admitted to the Royal Saskatchewan Provincial Mental Hospital. The average daily number of Saskatoon patients in this institution is about 300. As there is a general reluctance on the part of relatives to commit patients to large mental hospitals, it is reasonable to assume that many needing psychiatric treatment in hospital were denied this treatment to a distant mental hospital and many diagnosed cases. The patients: (a) are far from home (b) are separated from his family (c) suffers from the stigma associated with a mental hospital (d) receives a lower standard of hospital care - for example the daily cost per patient in Provincial Mental Hospital is about one-quarter that of a patient in a general hospital.



1 15. General hospitals have more than three
2 times the number of staff for the same number of patients.
3 The Mental Hospitals are overcrowded. Some times more
4 than 100 patients sleep in one room with the beds almost
5 touching.

6 16. During the whole of 1959, only 200 Saskatoon residents
7 psychiatric illnesses could be treated in the University
8 Hospital. Since the stay of each patient averaged less
9 than one month, the approximate number of Saskatoon Resi-
10 dents treated at any one time in the University Department
11 of Psychiatry was 15 compared to nearly 300 in the Saskat-
12 chewan Hospital in North Battleford. Furthermore, the
13 family doctor was not able to treat his own patients in
14 this ward, for it is a teaching ward which admits from all
15 of Saskatchewan and so cannot meet all the service needs
16 of the Saskatoon General Practitioners.

17 17. The General Practitioner should be recogni-
18 zed as the key person in the treatment of mental disorders.
19 He should have proper training and facilities to carry out
20 this responsibility.

21 18. He should be able to consult freely with
22 the teaching staff in the Department of Psychiatry at the
23 University, with private psychiatrists, and with the staff
24 at the Mental Health Clinics. For this to be possible,
25 more psychiatrists will be needed at the University, in
26 private practice, and at the MacNeill Clinic.

27 HOSPITALS

28 19. This city needs 100 to 150 psychiatric beds
29 in its General Hospitals; then no Saskatoon resident would
30 need at any time to go elsewhere for hospital treatment.



Some times more than 100 patients sleep in one room with the beds almost touching.

Psychopathic illnesses could be treated in the University Hospital. Since the stay of each patient averaged less than one month.

Of psychiatry was 15 compared to nearly 300 in the Saskatchewan Hospital in North Battleford. Furthermore, the general doctor was not able to treat his own patients in this ward for it is a teaching ward with admits from all of Saskatchewan and he cannot meet all the service needs of the Saskatchewan General Practitioners.

The General Practitioner should be recognized as the key person in the treatment of mental disorders. He should have proper training and facilities to carry out the treatment of his patients.

He should be able to consult freely with the teaching staff in the treatment of his patients at the University with private psychiatrists, and with the staff at the nearest mental hospital. For this to be possible,

in the General Hospital; then no Saskatchewan resident would need at any time to go elsewhere for hospital treatment.



1 This could be provided by incorporating, as we do surgical
2 and maternity wards etc., in large general hospitals, psy-
3 chiatric wards of 30 to 50 bed size. The general practi-
4 tioner would then be able to admit his own psychiatric
5 patients in these psychiatric beds. He would need and
6 should receive the adequate support of a psychiatric
7 specialist as he now receives other specialist advice and
8 help.

9 20. Many psychiatric patients discharged to
10 their homes need continued professional assistance. Visit-
11 ing nurses, social workers and other special therapists
12 should be available to help the General Practitioner pro-
13 vide this home care.

14 21. When a patient who has been discharged from
15 an acute hospital unit still needs nursing care, he should
16 be admitted to a chronic treatment service near a General
17 Hospital. We envisage a floor or wing of a general hospital,
18 or a pavilion type of convalescent hospital, attached
19 to a general Hospital for administration and services but
20 requiring greatly decreased staff, so providing economies
21 in operation. The psychiatric patient requiring this
22 continued service could be admitted to the same building
23 as the long-term physically sick. Here, as elsewhere, the
24 ultimate goal should be return to the community.

25 22. It is obvious to the Saskatoon Board of
26 Trade from our studies that our mentally ill, who comprise
27 a substantial percentage of all those requiring medical care
28 in Saskatchewan, are receiving very unfair consideration.
29 In the last hospital year, 1960-61 there were approximately
30 4,800 beds in our mental hospitals, at an estimated cost



1 of \$9,000,000, including Doctors, an average cost of
2 \$1,875 per bed.

3 23. During the same period of review there were
4 approximately 6,000 beds for the physically ill at an es-
5 timated cost of \$33,000,000, not including Doctors, or an
6 average of \$5,500 per bed, plus Doctors' care.

7 24. The rehabilitation of mental patients given
8 proper care is surprisingly high. Of 100 patients treated
9 at the University of Saskatchewan, an average period in
10 hospital of 28 days, 96 were discharged as cured, 4 reverted
11 to North Battleford. Of the 96 discharged 15 returned for
12 further treatment and the remaining 81 are leading useful
13 and happy lives.

14 25. For the reasons advanced above, we feel
15 that an adequate Mental Care program is of the utmost
16 urgency.

17 AGED AND CHRONICALLY ILL

18 26. We will now deal briefly with the care or
19 lack of proper care and facilities for the aged and chroni-
20 cally ill.

21 27. Many of the views that we have expressed in
22 regard to the mentally ill apply with equal significance
23 to the aged and chronically ill. This applies specifically
24 to the needs of these two groups in respect to the extension
25 of the facilities of the existing general hospitals, in
26 order that they may receive adequate general and specialized
27 medical care.

28 28. Many authorities now recognize the desira-
29 bility of having all patients, mentally, chronically and
30 acutely ill in different wings of one general hospital,



During the same period of review there were

approximately 5,000 beds for the physically ill as an es-

timated cost of \$35,000,000, not including doctors, or an

The rehabilitation of mental patients given

proper care is surprisingly high. Of 100 patients treated

at the University of Saskatchewan, an average period in

hospital of 28 days. 95 were discharged as cured, 4 reverts

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that an adequate mental care program is of the utmost

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of the physically ill and facilities for the aged and chronic

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regard to the mentally ill apply with equal significance

to the aged and chronically ill. This applies specifically

to the needs of these two groups in respect to the external

of the facilities of the existing general hospitals, in

order that they may receive adequate general and specialist

medical care.

Many authorities now recognize the desir-

ability of different wings of one general hospital,



1 thus making all modern medical services available to each
2 group. It is reasonable to assume that chronic cases,
3 with such improved facilities and with rehabilitation
4 services could be taken care of in chronic wings for half
5 the cost of general hospital care.

6 29. Emotional problems are of particular impor-
7 tance in the care of the aged and chronically ill. It
8 therefore follows that adequate rehabilitation and social
9 services must be integrated with the provision of proper
10 hospital and medical care.

11 30. The provision of proper care for the aged
12 is of urgent importance. We believe that Geriatric Centres
13 or wings should be constructed in conjunction with our
14 general hospitals so as to eliminate the conditions already
15 referred to; to relieve congestion in the general hospitals
16 and to make readily available nursing and medical services
17 of all kinds as they may be necessary.

18 31. We believe that we have brought to your
19 attention the three fields of medical care which are most
20 urgently required and to which government aid and direction
21 may properly be directed.

22 32. We believe that encouragement should be
23 given to voluntary service and indemnity plans for prepaid
24 medical care and that government should concern itself
25 only with those unable to care for themselves.

26 33. We believe that state medicine would inhibit
27 and cripple the outstanding medical progress that has
28 resulted in this Canada of ours from our freedom of choice
29 and the opportunity it affords for individual and group
30 development. And we believe that the compulsion inherent



1. It is essential to assure that chronic cases, with such improved facilities and when rehabilitation services could be taken care of in chronic wings for half the cost of general hospital care.

2. The cost of general hospital care, professional problems and of particular importance in the care of the aged and chronically ill. It therefore follows that separate rehabilitation and chronic services must be integrated with the provision of proper hospital and medical care.

3. The provision of proper care for the aged in an organized manner. We believe that certain chronic cases or wings should be constructed in conjunction with our general hospitals so as to eliminate the conditions which are now prevailing.

4. and to make readily available nursing and medical services of all kinds as they may be necessary.

5. We believe that we have brought to your attention the three fields of medical care which are most urgently required and to which government aid and direct aid may properly be extended.

6. We believe that encouragement should be given to voluntary action and leadership plans for preparing medical care and that government should remain itself only with the ability to care for themselves.

7. We believe that acute medical care should be made and include the outstanding medical programs that have emerged in this country of care from our freedom of choice and the opportunity it affords for individual and group development. And we believe that the competition inherent



1 in state medicine is as repugnant to the Canadian people
2 as would be the high costs and taxation that would inevi-
3 tably follow.

4 THE CHAIRMAN: Thank you, Mr. Hazen. Now,
5 Mr. Woodward, have you anything to add?

6 MR. WOODWARD: No, thank you. I think apart
7 from the fact I am largely responsible for a good deal of
8 the verbiage in this Brief, I do not think I could add
9 anything.

10 THE CHAIRMAN: Mr. Tubby?

11 MR. TUBBY: There is only one point. As
12 far as our Province is concerned the residents of the Pro-
13 vince are well taken care of as far as hospital care is
14 concerned with our hospital plan where they pay premiums
15 and we all have use of the hospitals, even the indigent
16 people because the municipalities take care of their hos-
17 pital premiums, so in case of illness the charge does not
18 go on the municipality. I think we can be sure that no
19 one in this Province is suffering from the fact that they
20 cannot get hospital care.

21 The only point appears to be that when they
22 get into hospital naturally the medical care is there for
23 them, and the only point seems to me to be then that perhaps
24 the doctors are not providing or we know they are providing
25 a certain amount of this medical care for them and they
26 are not being paid. People who are indigents and there is
27 no way of these people paying their doctors and it seems
28 while this may be painful to the doctors themselves, there
29 has not been too much public outcry as far as doctors are
30 concerned because of this.



1 The whole problem as far as our Province
2 is concerned is to me anyway, the fact that there is a
3 very small percentage of the population who are not perhaps
4 able to pay their doctor bills.

5 THE CHAIRMAN: Mr. Matheson?

6 MR. MATHESON: Mr. Chairman, on page 4 of
7 the Brief under paragraph 19 we mention that we feel that
8 the care of the mentally and chronically ill could be taken
9 care of by attaching it to our general hospitals psychia-
10 tric wards of 30 to 50 bed size and similarly wards for
11 the chronically ill.

12 THE CHAIRMAN: Wards or wings?

13 MR. MATHESON: Well, our idea is wards
14 rather than wings.

15 THE CHAIRMAN: The experts told us in the
16 last couple of days it should be wings and not wards.

17 MR. MATHESON: We have argued with them for
18 some time and we are still sticking to our guns that it
19 should be wards. We do not feel these wards necessarily
20 should be attached to the smaller general hospitals in the
21 Province, we do not think it is practical, but we do think
22 they should be attached to the larger hospitals. That is
23 a point I want to bring out.

24 THE CHAIRMAN: Well, at the risk of perhaps
25 pointing out an inconsistency in your position, is it not
26 a fact that you sent a delegation to the Department to ask
27 that a wing be attached to the new St. Paul's Hospital for
28 psychiatric patients?

29 MR. MATHESON: I think probably in our
30 presentation to the Department of Health that we specified

...no way, one fact that there is a
very small percentage of the population who are not perma-
nently able to pay their debts.

THE CHAIRMAN: Mr. Matthews?

Mr. Matthews, on page 10 of
the final report paragraph 15 we mention that we feel that
the case of the mentally and chronically ill could be
one of the most important in our general health and psychi-
atric work of 30 or 40 years ago and similarly works for

THE CHAIRMAN: Well, on page 10

Mr. Matthews, we have ideas as to what

...the work is.

THE CHAIRMAN: The experts told us in the

last couple of days that we should be working on

the work of the hospital. We have a great deal of work

to do and we are still working on our plans for

the future. We do not feel that we are necessarily

concerned with the work of the hospital in the

future. We do not think it is practical, but we are

concerned with the work of the hospital in the

future. We are working on it.

THE CHAIRMAN: Well, as the risk of persons

committing suicide is a consideration in your work, is it not

so that you have sent a delegation to the hospital to get

some more information on this new method of hospital for

the future?

Mr. Matthews: I am not sure.

...the Department of Health that we should



1 a ward instead of a wing. It may have said "wing" in our
2 Brief. We want a wing which would take care of one ward
3 for the mentally ill and another ward for the chronically
4 ill, not exactly a wing for the mentally ill alone. We
5 felt at that time it was better to have an additional
6 wing added on to the hospital which could accommodate both
7 the mentally ill and the chronically ill.

8 THE CHAIRMAN: What was the result of your
9 representations?

10 MR. MATHESON: So far I do not think we have
11 reached any agreement at all with the Government, but we
12 are still working on it.

13 THE CHAIRMAN: In the meantime the building
14 is going up?

15 MR. MATHESON: In the meantime the building
16 is going up.

17 MR. HAZEN: If I may add a further word to
18 that. I think, rather than thinking, and I think it was
19 expressed properly in the paper, that there should be a
20 ward for the mentally ill and also a ward for the chronical-
21 ly ill and in reaching the desired size it might be
22 necessary to build a wing. We were not thinking in terms
23 of a wing, we were thinking of one floor of one wing. I
24 do not think there was any confusion in the minds of the
25 Minister of Health of this Province or his deputy when we
26 made that presentation.

27 THE CHAIRMAN: Let me put it this way: If
28 you were just concerned with getting space within a build-
29 ing your request should have been made to the management.

30 MR. HAZEN: No, because it would have



1 required additional space. The present plans for the build-
2 ing envisage all the space being used for necessary services
3 to take care of the acutely physically ill and no provision
4 was made in the plans to take care of either mentally ill
5 or chronically ill people. An extension to the building
6 would be required either in the form of an additional
7 floor or some other form to give us some thirty to fifty
8 beds for the mentally ill and the same number for the
9 chronically ill.

10 MR. MATHESON: We did approach management
11 before we approached the Department of Health, Mr. Chairman.

12 THE CHAIRMAN: Well, I do not know what
13 may ultimately be your recommendation, but I suppose you
14 won't be too offended if we accept the advice of the experts
15 rather than the lay-man.

16 MR. MATHESON: No, although we do feel our
17 opinions on this matter should be given a consideration,
18 because we have conducted many, many hours of consultation
19 and we consider we know something about this situation.
20 As individuals we do not know a great deal ourselves but
21 we did consult with others whom we feel did.

22 THE CHAIRMAN: You say there is a group in
23 the Province economically incapable of taking care of their
24 own medical needs. I am paraphrasing the last part of
25 paragraph 8 on page 2. Have you got an estimate, either
26 percentage-wise or in round figures, of that group, the
27 size of that group?

28 MR. TUBBY: The point I was trying to make
29 is, as far as that group is concerned, it is pretty well
30 only their doctors bills they are not able to take care of,



1 The first thing I noticed when I stepped out of the car was
2 the cold. It was a sharp contrast to the warm blanket of the car.
3 I was alone in the room and the only sound was the ticking of the clock.
4 It was a strange feeling, a mix of excitement and nervousness.
5 I had heard so much about the place, but now it was real.
6 I took a deep breath and stepped out into the world.
7 The air was crisp and clean, a welcome change from the stuffy car.
8 I looked up at the sky and felt a sense of peace.

9 I had heard so much about the place, but now it was real.
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1 because they are taken care of as far as hospital accommo-
2 dation is concerned.

3 THE CHAIRMAN: What is the size of that
4 group?

5 MR. HAZEN: I don't think we could estimate
6 that, Mr. Chairman, not from our present position with the
7 research that we have done on it. We have used that figure
8 of some sixty to seventy percent of the people are covered
9 by voluntary medical plans, and a certain percentage of
10 the remainder, that is half say, of thirty, forty percent,
11 take care of themselves, because they feel that is more
12 desirable, and perhaps the group of indigents who are un-
13 able to take care of themselves may be ten to twenty per-
14 cent. Among that group of people who are unable or unwill-
15 ing to take care of themselves, I think must be considered
16 a large number who are quite capable of doing it, but
17 prefer not to. They spend their money on other things,
18 and have no money left over for medical care.

19 THE CHAIRMAN: That is to pay a medical
20 premium?

21 MR. HAZEN: They pay their money for other
22 things, and I could tell you a few that come readily to
23 mind.

24 THE CHAIRMAN: This may be redundant, but I
25 want to put a question that I have put to a number of
26 delegations who have been before us in the last few days,
27 as to the matter of priority. Accepting that the Province
28 of Saskatchewan has the economic capacity to do one or two
29 things out of a possible four, five, or six, in the health
30 service, or the health care field, have you a considered



1 because they are taken care of as far as hospital accom-
2 modation is concerned.

3 THE CHAIRMAN: What is the size of this

4
5 MR. HAZEN: I don't think we could estimate

6 that, Mr. Chairman, not from our present position with the
7 research that we have done on it. We have used that figure
8 of some sixty to seventy percent of the people are covered

9 by voluntary medical plans, and a certain percentage of
10 the remainder, that is half say, of thirty, forty percent,

11 take care of themselves, because they feel that as more

12 desirable, and perhaps the group of indigents who are un-

13 able to take care of themselves may be ten to twenty per-

14 cent. Among that group of people who are unable or unwill-

15 ing to take care of themselves I think must be considered

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18 and have no money left over for medical care.

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20 MR. HAZEN: They pay their money for other

21 things, and I could tell you a few that come readily to

22 THE CHAIRMAN: This may be redundant, but

23 want to put a question that I have put to a number of

24 delegations who have been before us in the last ten days,

25 as to the matter of priority. Accepting that the Province

26 of Saskatchewan has the economic capacity to do one or two

27 things out of a possible four, five, or six, in the health

28 service, or the health care field, have you a considered



1 view as to which of the various segments of the health
2 service fields should be dealt with first?

3 MR. HAZEN: I feel, sir, that I can answer
4 that question for our Committee and Board, and I think it
5 is fairly evident from our Brief that we feel the field
6 of mental illness is the one that should be tackled first.
7 You will recall that we made a presentation to the Saskat-
8 chewan Advisory Committee on Medical Care, and at that
9 time we dealt very briefly with the general field of self-
10 reliance and freedom of choice, because we felt that the
11 position of the Province was compromised to the extent that
12 there would not be any usefulness in developing that argu-
13 ment, so we dealt with the three fields, mentally ill,
14 chronically ill, and aged, and we feel that that is the
15 order for spending the funds, as they become available.
16 The physically ill, it seems to me, are quite adequately
17 taken care of at the present time, and probably will be
18 so in the future without any addition to our capacities,
19 excepting perhaps more hospital space, which is undoubtedly
20 required, and more professional people, not only doctors,
21 but the ancillary services, but we feel that the field of
22 mental illness, although it has progressed greatly in
23 science and they are able to do things that they were un-
24 able to do five or ten years ago, is handicapped both by
25 restriction of space available and number of people. This,
26 I suppose, becomes a matter of finance. In other words,
27 if enough money had been devoted to mental illness, then
28 it would be in the same position as acute illness, but
29 under present circumstances the mentally ill are receiving
30 very poor care. The chronically ill I think, are in much



services fields should be dealt with first?

MR. HARRIS: I feel, sir, that I can answer

that question for our Committee and Board, and I think it

is fairly evident from our Brief that we feel the field

of mental illness is the one that should be tackled first.

You will recall that we made a presentation to the Task-

Force Advisory Committee on Medical Care, and at that

time we dealt very briefly with the general field of self-

reliance and freedom of choice, because we felt that the

position of the Province was compromised to the extent that

there would not be any realness in developing that argu-

ment, so we dealt with the three fields, mentally ill,

chronically ill, and aged, and we feel that that is the

position of the Province.

In the physically ill, it seems to me, are quite adequately

taken care of at the present time, and probably will be

so in the future without any addition to our capacities.

Excepting perhaps more hospital space, which is undoubtedly

required, and more professional people, not only doctors,

nurses, and so on, but also social workers, and so on.

That is the position of the Province.

Now, if we turn to the mentally ill, the position is

quite different. There is a restriction of space available and number of people. That

I suppose, becomes a matter of finance. In other words,

if enough money had been devoted to mental illness, then

it would be in the same position as acute illness, but

under present circumstances the mentally ill are receiving

very poor care. The chronically ill I think, are in much



1 the same position, but I don't know whether their position
2 is as pitiable as the mentally ill. The medically ill
3 suffer an acute spasm, and can be restored to their family
4 almost immediately. The chronically ill are a little more
5 serious, and it may recur time and time again, but I think
6 it should be the mentally ill, the chronically ill, and
7 the aged, all three are to our mind of paramount account
8 and far more important than the government going ahead
9 in this Province, going ahead with prepaid medical care,
10 and not touching on these people at all.

11 COMMISSIONER FIRESTONE: Mr. Hazen, in
12 paragraph 7 you say that you are in favour of medical care
13 services being available to all citizens, and you speak,
14 and I quote: "Best medical care in the widest possible
15 sense". I take it from what you say here that you are in
16 favour of a comprehensive medical care program?

17 MR. HAZEN: This is a generalization, Mr.
18 Firestone, which I think expresses our feeling in regard
19 to it very well.

20 COMMISSIONER FIRESTONE: Thank you. I take
21 it that as far as paying for such a program, you advocate
22 that those who can afford it pay for it themselves, and
23 those who cannot afford it, the State pays for it, and by
24 that group you cover the indigent and the medically indigent?

25 MR. HAZEN: Yes, sir.

26 COMMISSIONER FIRESTONE: You say in paragraph
27 8 that you feel that government assistance should be pro-
28 vided for such a plan. When you speak of government assis-
29 tance, do I take it that this includes Federal, Provincial,
30 and Municipal?



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is as difficult as the mentally ill. The medically ill
suffer an acute attack, and can be restored to their family
almost immediately. The chronically ill are a little more
serious, and it may require time and time again, but I think
it should be the mentally ill, the chronically ill, and
the aged, all three are to our mind of paramount account
and far more important than the government policy ahead
in this Province, going ahead with prepaid medical care,
and not touching on these people at all

COMMISSIONER HIRSTONE: Mr. Hirstone, in
paragraph 7 you say that you are in favour of medical care
services being available to all citizens, and you speak
and I quote "Best medical care in the widest possible
terms." Take it from what you say here that you are in
favor of a comprehensive medical care program
for all. This is a generalization, Mr.
Hirstone, which I think expresses our feeling in regard
to it very well.

COMMISSIONER HIRSTONE: Thank you. I take
it that as far as paying for such a program, you advocate
that those who are able to pay for it themselves, and
those who cannot afford it, the State have to it, and by
that group you cover the indigent and the medically indigent.
MR. HIRSTONE: Yes, sir.

COMMISSIONER HIRSTONE: You say in paragraph
8 that you feel that government assistance should be pro-
vided for such a plan. When you speak of government assis-
tance, do I take it that this includes Federal, Provincial,
and Municipal



1 MR. HAZEN: I think that is right, Mr.
2 Firestone. Under the present setup I believe that the
3 illnesses of the indigent are taken care of primarily
4 through the Social Welfare Department of their Municipality,
5 who are subsidized and financed through the Provincial
6 Government, and ultimately through the Dominion Government.

7 COMMISSIONER FIRESTONE: In other words,
8 you would feel that if a comprehensive program is developed,
9 the Federal Government should make a contribution to a
10 Provincial scheme?

11 MR. HAZEN: I think I can answer that in
12 the affirmative, sir.

13 COMMISSIONER FIRESTONE: Thank you. You
14 are in favour of a voluntary system as distinct from a
15 compulsory system?

16 MR. HAZEN: Yes, I might say that we are
17 very much concerned with the insidious spread of socialism
18 in all fields of Canadian life, in fact in all fields of
19 life on this continent, and we feel that the preservation
20 of the democratic system under which Canada and the life on
21 this continent developed is worth fighting for, and to take
22 a factor such as medical care and develop socialism through
23 it is contrary to the whole system of our country.

24 COMMISSIONER FIRESTONE: I take it from your
25 answer, sir, that the answer to my question, whether you
26 are in favour of a voluntary scheme, is ---?

27 MR. HAZEN: Yes.

28 COMMISSIONER FIRESTONE: If there were to
29 develop in Canada a Federal Plan for financial assistance
30 to Provincial programs or plans for health care services,



1 comprehensive health care services of the type which you
2 have described, and if that plan, this Federal Plan now,
3 this Federal contribution would be subject to certain
4 conditions, and I would like to outline to you some of
5 those conditions, to find out whether they would be
6 acceptable to you. If the first condition were that such
7 grants would be made if the provinces that want to avail
8 themselves of that grant would meet a minimum standard of
9 medical care. The second that a majority of provinces, and
10 a majority of population of Canada would join such a plan,
11 or would make use of the facilities offered under such a
12 plan, and that the third condition would be that it would
13 be left up to a province to decide whether they wished to
14 have a voluntary plan or a compulsory plan, and that the
15 fourth condition would be that if a province decided on a
16 voluntary plan, that a majority of the population within
17 that province would be covered, say 75% to 85%. If such
18 a plan were put forward by the Federal Government, which
19 leaves it to the judgment and discretion of the people of
20 each province to make up their own mind whether they want
21 a voluntary or a compulsory scheme, would your Saskatoon
22 Board of Trade support such a proposal?

23 MR. HAZEN: I wouldn't give a categorical
24 answer to that question. It is a little too complex for
25 me to follow verbally. Perhaps if I saw it in written form
26 and we were able to discuss it we could give you an answer.

27 COMMISSIONER FIRESTONE: May I leave it to
28 you to obtain the record of the discussion that has taken
29 place this afternoon, and then consider it among yourselves
30 and let this Commission have in writing your considered



have described, and it has been, this Federal plan now
this Federal constitution would be subject to certain
conditions, and I would like to outline to you some of
these conditions, to find out whether they would be
acceptable to you. If the first condition were that each
province should be made its own province that want to have
themselves of that grant would meet a minimum standard of
needs. The second that a majority of provinces, and
a majority of population of Canada would join such a plan.
or would make use of the facilities offered under such a
plan, and the third condition would be that it would
be left up to a province to decide whether they wished to
have a voluntary plan or a compulsory plan, and that the
total population would be that if a province decided on a
voluntary plan, that a majority of the population within
that province would be covered, say 75% to 85%. If such
a plan were put forward by the Federal Government, which
leaves it to the judgment and discretion of the people of
each province to make up their own mind whether they want
a voluntary or a compulsory scheme, would your Saskatchewan
kind of trade support such a proposal?

Mr. Harkin: I wouldn't give a categorical
answer to that question. It is a little too complex for
me to follow verbally. Perhaps if I saw it in written form
and we were able to discuss it we could give you an answer.
COMMISSIONER THOMPSON: May I leave it to
you to obtain the record of the discussion that has taken
place this afternoon, and then consider it among yourselves
and let this Commission have an evening with consideration



1 view on the subject, and if your view is either yes or no,
2 or if it is a qualified view, could you in addition to
3 your answer give us the reasons for your answer?

4 MR. HAZEN: We will be very happy to do
5 that and give it very careful consideration, and we promise
6 you quite a prompt answer.

7 COMMISSIONER McCUTCHEON: Mr. Hazen, have
8 you any evidence that the so-called indigent and medically
9 indigent, I am not sure just what that latter term means,
10 except it probably means people who prefer to use their
11 money for something else than pay the doctor, but have you
12 any evidence that there is a serious lack of medical care
13 in that group? Is that group being taken care of at
14 present?

15 MR. HAZEN: It is our belief, and I will
16 support this with my personal opinion, that they are given
17 very adequate and complete medical care. I don't believe
18 that because a person is indigent he suffers with anything
19 that a person who is able to pay for himself could have.
20 In other words, I think that the medical profession in this
21 Province, and particularly those who I know personally,
22 have treated all people alike, whether they have been able
23 to pay their bills, or have not been able to pay their
24 bills. During the depression, when a great many more of
25 us were indigent than there are today, there was no lack of
26 the best medical care for people at that time.

27 COMMISSIONER McCUTCHEON: That, I take it,
28 is the reason that in looking at the terms of reference
29 and the priorities that you have come up with, the three
30 priorities that you have mentioned this afternoon ---



1 view on the subject, and if your view is either yes or
2 on it is a qualified view, could you in addition to
3 your answer give us the reasons for your answer?

4 MR. HAZEN: We will be very happy to do
5 that and give in very careful consideration, and we promise
6 you quite a prompt answer.

7
8 You say evidence that is so-called indigent and medically
9 indigent. I am not sure just what that latter term means,
10 except it probably means people who prefer to use their
11 money for something else than pay the doctor, but have you
12 any evidence that there is a serious lack of medical care
13 in that group? Is that group being taken care of at
14 present?

15 MR. HAZEN: It is our belief, and I will
16 support this with my personal opinion, that they are given
17 very adequate and complete medical care. I don't believe
18 that because a person is indigent he suffers with anything
19 that a person who is able to pay for himself could have.

20 In other words, I think that the medical profession in this
21 country, and particularly those who I know personally,
22 have treated all people alike, whether they have been able
23 to pay their bill or have not been able to pay their
24 bill. During the depression, when a great many more of
25 us were indigent than there are today, there was no lack of
26 the best medical care for people at that time.

27 COMMISSIONER McCLELLAN: That, I take it,
28 is the reason that in looking at the better of reference
29 and the practice that you have come up with, the more



1 MR. HAZEN: That is one of the reasons
2 behind it, sir.

3 THE CHAIRMAN: Thank you very much, Mr.
4 Hazen and gentlemen. You have made your position clear in
5 this concise Brief, and with the further information that
6 you will furnish us in due course, the whole matter will
7 receive our careful consideration.

8 MR. HAZEN: Thank you very much.

9 THE CHAIRMAN: The next submission will be
10 from the Saskatchewan Wheat Pool.

11
12 ---EXHIBIT NO. 103: Submission of the Saskatchewan
13 Wheat Pool.

14
15 S U B M I S S I O N O F
16 THE SASKATCHEWAN-WHEAT POOL

17 APPEARANCES:

18 MR. L.A. BOILEAU

19 MR. ROBERT PHILLIPS

20 MR. PHILLIPS: Mr. Chairman and Members of
21 the Commission: We represent the Saskatchewan Wheat Pool.
22 Our principal spokesman is Mr. Louis Boileau. He is the
23 Vice-President of the Wheat Pool, and has been for two
24 years. He is primarily a farmer. He has been a delegate
25 to the Wheat Pool for nineteen years, from 1942 until the
26 present. He has been a Director for seven years. Between
27 the years 1927 and 1947, a twenty-year period, he was
28 Municipal Secretary in the northern half of the Province,
29 in the RM 431, in St. Louis, in the Prince Albert area.
30



RY/ss

1 Saskatchewan Wheat Pool is a farmer-owned
2 grain and livestock marketing co-operative. Its interest
3 before this Royal Commission is purely to speak on behalf
4 of farmers, particularly those who are resident on the
5 farms of Saskatchewan. This submission will make two
6 principal points:
7 point i. Because farms are often isolated the farmer is
8 placed at a real disadvantage in the matter of health care
9 and medical facilities and services. The Pool submits that
10 this commission be made aware of some of the factors
11 affecting Saskatchewan farmers and health care and
12 that in its deliberations it consider these factors
13 in reaching its conclusions.
14 point ii. Because farmers live apart on individual farm-
15 steads and often in isolation, they are simply not
16 able to take advantage of many of the pre-paid
17 health care plans in operation in the province. The
18 Pool submits that farmers should not remain contin-
19 ually in the position that they cannot budget in
20 the advance for health care and that this commission
21 make recommendations urging universal health care
22 of coverage with provision for payment on behalf of
23 all citizens, farmers and townsmen alike, who cannot for
24 one reason or another meet the costs themselves.
25 Saskatchewan Wheat Pool welcomes this oppor-
26 tunity to appear before this Royal Commission on Health
27 Services and respectfully submits the following:
28 Saskatchewan Wheat Pool has prepared this
29 submission to bring to your attention some of the conditions
30 affecting Saskatchewan farmers in the availability and



Saskatchewan Wheat Pool is a farmer-owned

entity and livestock marketing co-operative. Its business

before this Royal Commission is purely to speak on behalf

of farmers, particularly those who are small and

isolated.

Principal points:

1. Because farms are often isolated the farmer is

at a real disadvantage in the matter of health care

facilities and services. The Pool submits that

this Commission be made aware of some of the factors

affecting Saskatchewan farmers and health care and

that in its deliberations it consider these factors

in reaching its conclusions.

ii. Because farmers live apart on individual farms

stands and often in isolation, they are simply not

able to make advantage of many of the pre-paid

health care plans in operation in the province. The

Pool submits that farmers should not remain contin-

ually in the position that they cannot budget in

advance for health care and that this Commission

make recommendations urging universal health care

coverage with provision for payment on behalf of

citizens, farmers and townsmen alike, who cannot for

one reason or another meet the costs themselves.

It is to appear before this Royal Commission on Health

Services and respectfully submits the following:

Saskatchewan Wheat Pool has prepared this

submission to bring to your attention some of the conditions

affecting Saskatchewan farmers in the availability and



1 accessability of health care facilities and service. By
2 health care is meant the total of medical, surgical,
3 dental and hospital services for both treatment and diag-
4 nosis as well as sickness prevention.

5 Saskatchewan Wheat Pool is a voluntary co-
6 operative, owned and operated by its farmer members. Its
7 principal business is the marketing of grain and livestock
8 produced by members. It also operates a flour mill, a
9 vegetable oilseed processing plant and a printing and
10 publishing division which produces a weekly farm newspaper.
11 In the fiscal year ended July 31, 1959 a total of 76,977
12 individual farmers delivered some of their grain and live-
13 stock to Pool facilities and received excess charges re-
14 funds (the patronage dividend). The following year, ended
15 July 31, 1960 refunds went to 77,500 farmers. Some farmers
16 who did not deliver grain or livestock during those years
17 remain active members because they remain active farmers.
18 In recent years the Pool's country elevator division has
19 handled about one-half of all grain marketed in the province;
20 the Pool's livestock division handles about 50 per cent of
21 the cattle and calves, 30 per cent of the hogs and 40 per
22 cent of the sheep and lambs. The Pool speaks especially
23 for farmers who are members of the co-operative but it
24 also speaks for the provinces's agricultural industry as
25 a whole.

26 The Pool's concern is for farmers who live
27 on their land at least part of the year. There are varied
28 estimates about how many individuals this involves. The
29 1956 inter-census estimate by the Bureau of Statistics
30 gave as 103,391 the number of farms in Saskatchewan. The



necessity of health care facilities and services. By

health care is meant the total of medical, surgical,

dental and hospital services for both treatment and dis-

ease as well as disease prevention.

Sarasota County Health Pool is a voluntary co-

operative, owned and operated by its farmer-members. Its

principal business is the marketing of grain and livestock

products by members. It also operates a flour mill, a

vegetable oilseed processing plant and a printing and

publishing division which produces a weekly farm newspaper

In the fiscal year ended July 31, 1969 a total of 75,000

livestock farmers delivered some of their grain and live-

stock to Pool facilities and received excess charges re-

turns (the percentage dividend). The following year, ended

July 31, 1960 returns went to 7,500 farmers. Some farmers

who do not deliver grain or livestock during these years

remain active members because they remain active farmers.

In recent years the Pool's county elevator division has

handled about one-half of all grain marketed in the province

the Pool's livestock division handles about 50 per cent of

the cattle and calves, 30 per cent of the pigs and 40 per

cent of the sheep and lambs. The Pool speaks especially

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on their land at least part of the year. There are varied

estimates about how many individuals this involves. The

1965 inter-county estimate by the Bureau of Statistics

gave as 103,000 the number of farms in Sarasota County. The



1 Saskatchewan Agriculture Department estimated in mid-1961
2 there were "about 90,000" farms in Saskatchewan. Estimates
3 of how many farmers actually live on these farms for at
4 least part of the year are more difficult to acquire. A
5 mailed questionnaire Saskatchewan Wheat Pool conducted by
6 itself in 1960 to determine some information and opinion
7 from farmers about farm machinery provides some data on
8 the question. At that time 88.3 per cent of the 880 farm-
9 ers who replied to the question said they live on their
10 land all year round; 5.8 per cent said they live on the
11 farm at least part of the year and 5.9 per cent said they do
12 not live on their farms at all but commute to the land
13 from residence elsewhere.

14 On the question of farm residence, the Pool's
15 1960 farm machinery survey showed a consistency of replies
16 from each of the 16 Wheat Pool districts which together
17 cover the entire cultivated portion of the province. The
18 survey demonstrated that in none of the 16 Wheat Pool
19 Districts do more than one-fifth of the farmers who replied
20 to the questionnaire live away from their land all or part
21 of the time. In fact for all districts at least four-
22 fifths are full-time residents of their farmsteads and in
23 some areas 90 per cent or more live on their farmsteads all
24 of the year. While these results may not have come from
25 a true sample experience leads the Pool to accept them as
26 being indicative of the farm population as a whole.

27

28

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Saskatchewan Agriculture Department estimated in mid-1961

of how many farmers actually live on these farms for at least part of the year are more difficult to acquire. A mailed questionnaire Saskatchewan Wheat Pool conducted by itself in 1960 to determine some information and opinion from farmers about farm machinery provides some data on the question. At that time 88.3 per cent of the 880 farmers who replied to the question said they live on their land all year round; 5.8 per cent said they live on the farm at least part of the year and 5.9 per cent said they do not live on their farms at all but commute to the land.

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districts is more than one-fifth of the farmers who replied to the questionnaire live away from their land all or part of the time. In fact for all districts at least four-fifths are full-time residents of their farmsteads and in some areas 90 per cent or more live on their farmsteads all or the year. While these results may not have come from a true sample experience leads the Pool to accept them as being indicative of the farm population as a whole.



TABLE A: DISTRIBUTION OF FARM RESIDENCE BY SASKATCHEWAN WHEAT POOL DISTRICTS - 1960

Number of farmers reporting from each of the 16 districts	Percentage of those reporting who live on their farms			
	All year round	Only part of year	Not at all	
1	50	88.0	10.0	2.0
2	40	95.0	2.5	2.5
3	34	88.24	2.94	8.82
4	33	81.82	9.09	9.09
5	47	91.49	4.26	4.25
6	66	81.82	7.58	10.60
7	58	89.66	8.62	1.72
8	46	89.13	4.35	6.52
9	50	92.0	6.0	2.0
10	51	86.27	11.77	1.96
11	63	84.13	4.76	11.11
12	54	92.59	5.56	1.85
13	70	85.71	10.0	4.29
14	60	93.33	1.67	5.0
15	44	93.18	-	6.82
16	56	89.29	1.79	8.92
District unidentified	58	82.76	5.17	12.07
Totals	880	88.3	5.8	5.9

(Source: compiled from results of a survey conducted in 1960 by Saskatchewan Wheat Pool)

When farms in this province were first settled the isolation and distances placed farmers and their families at a real disadvantage when it came to health services. One of the ever-present fears of the pioneer farmer was that his wife would have to be delivered of a baby in his isolated farm kitchen without benefit of medical aid and sometimes without even a neighbour's assistance. Another fear was that the farmer or a member of his family would face death alone in the farmstead home or even in the field. To a large extent improved transportation facilities have alleviated most of these fears but some still remain because the best health care service known to man cannot completely eradicate the special hazards of farm life away from neighbours and help.

Changes in farming mechanization in recent years have eliminated many aspects of isolation for those



1 able to use the improved roads and modern motor cars or
2 trucks. But for some of the more marginal farmers isolation
3 remains and may have become in fact less bearable as farms
4 become larger and distances between them greater. Farm-
5 steads now are seldom within walking distance of one another
6 and while roads and motorized vehicles are far superior to
7 animal power, communication may be cut off completely in the
8 dead of winter when roads are closed during storms. Even
9 the best of high-powered tractors are sometimes not as
10 efficient in blowing snow as was the horse who could find
11 his way and pull a sleigh without much attention from the
12 driver. Census compilations indicate the marked change in
13 farm size and in number of farms within Saskatchewan in the
14 last 20 years. In 1941, for example, there were an estima-
15 ted 126,900 farms in the province averaging 473 acres each.
16 Ten years later the number of farms was reduced to 112,018
17 and their average size increased to 551 acres. In 1956 the
18 inter-census estimates places the number of farms at
19 103,391 and their average size at 607 acres. The Pool's
20 survey of the farm machinery question in 1960 indicated the
21 average farm size among the 887 farmers who replied to the
22 questionnaire was something like 840 acres. While this
23 may be large for the provincial average there is no doubt
24 that average farm size for the province has increased app-
25 reciably since the 1956 inter-census estimates. Farms re-
26 maining are farther apart.

27 The Pool realizes the impossibility of attemp-
28 ting to equalize distances from all farmsteads to adequate
29 health care facilities. However, the Pool submits that
30 this Royal Commission be aware of the inequities of opportuni-



1. ... But for some of the more marginal farmers isolated
2. ... and may have become in fact less desirable as farms
3. ... become larger and distances
4. ... steady, now the
5. ... and while roads and motorized vehicles are far superior to
6. ... animal power, certain factors may be out of completely in
7. ...
8. ... the fact of high-powered tractors are sometimes not as
9. ... utilized in growing areas as was the horse who could find
10. ... a way and still a straight without much attention from the
11. ...
12. ...
13. ... farm size and in number of farms within boundaries in the
14. ... last 50 years. In 1911, for example, there were an estimated
15. ... and 150,000 farms in the province averaging 473 acres
16. ... years later the number of farms was estimated at 120,000
17. ... and their average size increased to 521 acres. In 1956 the
18. ... were estimated places the number of farms at
19. ... 101,391 and their average size at 607 acres. The 1960
20. ... survey of the 1950 machinery question in 1960 indicated a
21. ... average farm size among the 807 farmers who replied to the
22. ... questionnaire was somewhat like 800 acres. While this
23. ... may be taken for the provincial average there is no doubt
24. ... that average farm size for the province has increased app-
25. ... recedently since the 1950 inter-censal estimates. Farms re-
26. ... holding are larger, more
27. ... the fact realizes the impossibility of at-
28. ... tending to equalize distances from all farmsteads to adequate
29. ... health care facilities. However, the local authorities must
30. ... the Royal Commission be aware of the possibilities of opportu-



1 to acquire adequate health care between Saskatchewan rural
2 and urban populations and that this factor be considered
3 during this Royal Commission's deliberations.

4 The Research and Statistics branch of the
5 Saskatchewan Public Health Department supplied on request
6 the following data which shows the distribution of doctors,
7 hospitals, hospital beds and pharmacies in the province by
8 areas which the department calls Health Statistical Areas.
9 The Regina and Saskatoon areas appear best provided with
10 doctors, hospitals, hospital beds and pharmacies. The
11 Weyburn and North Battleford areas have high density of
12 both medical and hospital bed facilities but in some re-
13 spects figures for these centres are misleading because
14 each has a large institution for mental care whose facili-
15 ties are not generally available. The TB sanatorium at
16 Fort San is located in the Regina rural district, tending
17 to distort the picture there as far as the general public
18 is concerned.



...and ... have high density of
both medical and hospital facilities but in some re-
spects figured for more centers and ... because
each has a large institution for mental care where facili-
ties are not generally available. The ...
... is located in the ...
... as far as the general public
is concerned.



TABLE B: DISTRIBUTION OF THE NUMBER OF DOCTORS, HOSPITALS, HOSPITAL BEDS AND PHARMACIES BY SASKATCHEWAN PUBLIC HEALTH DEPARTMENT STATISTICAL AREAS - 1961

Statistical area and estimated population 1/	Description of Health Statistical area	Doctors (July 1961)	Hospitals 2/ (Dec. 1961)	Hospital Beds (Dec. 1961)	Pharmacies (Sept. 1961)
1 55,825	Swift Current city & district	44	14	400	23
2 26,049	Assiniboia area (no cities)	16	10	164	14
3 57,994	Weyburn, Estevan cities & district	43	13	1,288	22
5 79,898	Regina rural area	43	17	826	28
16 104,228	Regina city	199	6	1,456	52
6 54,690	Moose Jaw city and district	65	7	1,579	19
7 49,912	Rosetown area (no cities)	31	13	250	20
8 44,667	Saskatoon rural area	13	6	111	13
17 87,021	Saskatoon city	232	6	1,383	47
9 49,513	Humboldt-Wadena area (no cities)	22	11	272	18
10 81,971	Yorkton city and district	43	13	480	24
11 47,121	Melfort-Tisdale area (incl. Melfort city)	26	12	482	17
12 67,696	Prince Albert city & district	54	11	805	19
13 62,518	North Battleford city and district	64	18	1,642	31
14 11,761	Meadow Lake area (no cities)	7	3	47	3
15 18,784	Northern areas under gov't administration	6	10	114	2
Totals 899,648		908	170	11,299	352

- 1/ Saskatchewan Hospital Services Plan covered population. The DBS estimated population for 1960 was 910,000.
- 2/ Includes general hospitals, outpost hospitals, nursing homes under permit, Indian health nursing stations, Indian health services units, sanatoria, geriatric hospitals and institutions for mental care.
- 3/ The sanatorium at Prince Albert was closed July 4, 1961. The health department said it was assuming that the measured bed capacity of 219 was relocated, 146 to Fort San and 73 to Saskatoon sanatorium.

Source: Compiled from data supplied on request by the Research and Statistics Branch of the Saskatchewan Public Health Department (December 1961).

The disparity in availability of doctors and hospitals from one area to another demonstrates clearly that the more urban the complexity of the district the better the facilities. Table C relates population to the number of doctors, the number of hospitals and to the number of hospital beds.

TABLE 1. HOSPITALIZATION DATA FOR THE YEAR 1967			
Hospitalization Data		Description of Hospital	
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TABLE C: DISTRIBUTION OF DOCTORS, HOSPITALS AND HOSPITAL BEDS BY 1,000 OF POPULATION
FOR EACH OF THE SASKATCHEWAN PUBLIC HEALTH DEPARTMENT STATISTICAL AREAS -
1961

Health Statistical Area	Popula- tion	Doctors No. per 1,000	Hospitals No. per 1,000	Hospital beds 1/ No. per 1,000
1 Swift Current	55,825	44 1.78	14 .25	400 7.16
2 Assiniboia	26,049	16 .61	10 .38	164 6.3
3 Weyburn	57,994	43 .74	13 .22	1,288 22.2
5 & 16 Regina	184,126	242 1.31	23 .12	2,282 12.4
6 Moose Jaw	54,690	65 1.18	7 .12	1,579 28.9
7 Rosetown	49,912	31 .62	13 .26	250 5.01
8 & 17 Saskatoon	131,688	245 1.86	12 .09	1,494 11.34
9 Humboldt	49,513	22 .44	11 .22	272 5.49
10 Yorkton	81,971	43 .52	13 .15	480 5.86
11 Melfort	47,121	26 .55	12 .25	482 10.23
12 Prince Albert	67,696	54 .79	11 .16	805 11.89
13 North Battleford	62,518	64 1.02	18 .28	1,642 26.27
14 Meadow Lake	11,761	7 .59	3 .25	47 3.98
15 North areas	18,784	6 .31	10 .53	114 6.06
Totals and prov- incial average	899,648	908 1.00	170 .18	11,299 12.56

1/The cities of Moose Jaw, and Weyburn and North Battleford have large institutions for mental care which tend to distort the true incidence of doctors and hospitals per 1,000 of population. See also Table D.

Source: Compiled from data supplied by the Research and Statistical Branch of the Saskatchewan Public Health Department, December 1961.

The biggest urban areas provide the best health care services. As the urban quality of the community declines so does the quality of the health services. Regina and Saskatoon cities, for example, have the largest population concentrations, the greatest number of physicians both in total and per thousand of population, and one of the best records of hospital beds per thousand of population. The urban centres of Moose Jaw, Prince Albert, North Battleford and Weyburn all provide better health services (in terms of doctors and hospital facilities), both for their urban populations and for the neighboring rural populations, than do health statistical areas in which there is no major



1 urban community. This demonstrates that the farmer on the
2 farm is at a disadvantage to the urban dweller in availa-
3 bility of health care services. Not only does the farmer
4 have to travel longer distances to get to health centres
5 but sometimes he experiences inconveniences in acquiring
6 treatment once he does reach the urban centre merely because
7 he is from the country. For example, if he has to wait
8 long periods to see a doctor once he arrives, the waiting
9 poses a greater hardship for him than for the urban dweller.

10 Aside from the density of population depen-
11 dent on each doctor and hospital available there is also
12 the question of the quality of service available. Variation
13 in quality may be indicated by considering the following
14 data which shows a breakdown of the number of doctors in
15 the practice of medicine (with specialists in each area
16 noted in parenthesis), in government service, in clinics
17 and research jobs and the employed as hospital administra-
18 tors, in residences and non-practicing teaching jobs.
19 The cities of Regina and Saskatoon appear to provide the
20 most adequate specialist services. The cities of Moose
21 Jaw, North Battleford, Prince Albert, Swift Current and
22 Yorkton do have some specialists but the number in each of
23 these urban centres appears less than adequate to serve
24 both the urban centre and surrounding rural area. This
25 places the farmer at a disadvantage to the urban dweller
26 in availability of medical and surgical facilities.

27

28

29

30



1 urban community. This demonstrates that the farmer on
2 farm is at a disadvantage to the urban dweller in avail-
3 ability of health care services. Not only does the farmer
4 have to travel longer distances to get to health centres
5 and sometimes he experiences inconveniences in reaching
6 treatment once he does reach the urban centre merely because
7 he is from the country. The question is how to
8 improve a greater equality for him than for the urban dweller
9 - Apart from the density of population being
10 more on each doctor and hospital available there is also
11 the question of the quality of service available. Variation
12 in quality may be indicated by considering the following
13 facts which show a breakdown of the number of doctors in
14 the practice of medicine within specialists in each area
15 noted in parentheses. In government services in clinics
16 and hospitals, the number of specialists is very small
17 and the number of general practitioners is very large
18 and the number of specialists is very small
19 The number of specialists in government services is very small
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TABLE D: NUMBER OF PHYSICIANS BY NATURE OF PRACTICE IN SASKATCHEWAN 1961

City	Practicing physicians (specialists)	Gov't service	Clinics & Research	Administ. & teaching	Total for city	Adjoining rural area	Total
Saskatoon	177 (67)	11	15	29	232	13	245
Regina	165 (81)	27	7	-	199	43	242
Moose Jaw	42 (15)	13	1	1	57	8	65
Prince Albert	34 (9)	6	1	-	41	13	54
North Battleford	19 (4)	15	-	-	34	30	64
Swift Current	18 (1)	2	-	-	20	24	44
Yorkton	14 (1)	1	-	1	16	27	43
Weyburn	8 (0)	12	-	-	20	23	43
Melfort	7 (0)	-	-	-	7	19	26
						200	826
Additional rural areas						82	82
TOTALS	484 (178)	87	24	31	626	282	908

Distribution by job of 282 doctors in rural areas

Rural areas	271 (1)	6	5	-	282
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Source: Compiled from data in the Interim Report of the Advisory Planning Committee on Medical Care to the Saskatchewan Government (September 1961) and data from the Department of Research and Statistics, Saskatchewan Department of Public Health (December 1961).

The Pool submits that governments with jurisdiction over widely-scattered rural populations face complex problems when attempting to provide adequate health services to the non-urban areas. In Saskatchewan there have been generous attempts to offset the disparity of opportunity: air ambulance services make emergency treatment less distant, travelling clinics of one kind and another take specialist services into the countryside, public health nursing services attempt to equalize some forms of health care, the scattering of outpost hospitals and institutions of one kind and another contributes to the supply in rural areas of equipment and skilled services for treatment and diagnosis. There remains, however, a very real disparity in both the quantity and quality of trained doctors out large urban centres. The Pool appreciates the disinclina-



1 tion of some doctors to establish away from larger centres
2 where facilities may be so limited and consulting opportu-
3 nities so lacking as to place the individual physician at a
4 real disadvantage professionally. There may be more that
5 governments could do to encourage greater diversity of the
6 supply of doctors by providing, out of government funds,
7 improved diagnostic and treatment facilities and by attrac-
8 ting specially trained physicians and surgeons to settle in
9 smaller centres or at least to visit them professionally on
10 an occasional basis. Extension of this kind of specialist
11 service may go far to encourage more physicians in general
12 practice to remain located away from the large centres of
13 population. It could improve the quality of both diagnosis
14 and treatment and provide for the general practitioner away
15 from large centres consultative opportunities not now
16 available.

17 Quite apart from the disparity in actual
18 health service facilities in one area as compared with
19 another there is the additional disparity in pre-payment
20 opportunity as between the farmer and the townsman. Gener-
21 ally speaking pre-paid services are not as available to the
22 farm as to the urban citizen even though many of the exist-
23 ing plans have made attempts to extend beyond the community
24 in which they are centred. The two large voluntary medical
25 care insurance plans operating in Saskatchewan (Medical
26 Services Incorporated in Saskatoon and Group Medical Services
27 in Regina) have each attempted to provide their facilities
28 to some rural areas with only limited success. Medical
29 Services Incorporated, for example, has contracts with a
30 number of municipalities surrounding Saskatoon. But these



1 'insure' fewer than 60,000 persons of a total of more than
2 200,000 covered by Medical Services Incorporated plans.
3 Group Medical Services has comparable contracts with smaller
4 communities covering about 13,000 persons of a total ex-
5 ceeding 87,000 covered by Group Medical Services plans.
6 Each of the two pre-paid schemes covers non-operating rail-
7 way employees who live across the province and one of them
8 covers employees of both the Saskatchewan government and
9 Saskatchewan Wheat Pool outside of the urban centres where
10 the plans are concentrated. These are examples of attempts
11 to extend coverage beyond urban centres. In addition
12 governments have encouraged a number of health care schemes,
13 including municipal doctor plans and the public medical-
14 dental plan in the Swift Current area. Others are better
15 able to outline the nature of these various schemes than is
16 the Pool because others are more familiar with the various
17 provisions of each. However, it is the Pool's understand-
18 ing that farmers as farmers are on the whole generally
19 unable to pre-pay for health care services on anything like
20 the same basis as most residents of the larger urban
21 centres. Some of the available pre-paid plans cover groups
22 only and not individuals. Persons who leave or retire from
23 the employment must quit the group and be excluded from the
24 coverage. Plans which do provide coverage for individuals
25 usually have an age limit and often exclude the chronically
26 ill, both of which may be the most in need of adequate
27 health care. Many a farmer cannot comply with these
28 provisions and for this reason is at a real disadvantage
29 in trying to provide for himself and his family adequate
30 health care financed on a basis which he can afford and



1 for which he can budget in advance. The Pool submits that
2 some way must be found to alleviate this disparity.

3 Saskatchewan Wheat Pool holds that adequate
4 health care ought to be available to the farmer as to other
5 segments of Saskatchewan's population. By this is meant
6 both facilities for care--medical, surgical, dental, diag-
7 nostic and preventative--and opportunities for payment.
8 Existing arrangements provide the farmer something less
9 than equitable opportunity for health care and place him
10 at a considerable disadvantage in the matter of payment.
11 The Pool's position is that facilities must be extended
12 and improved to alleviate at least the worst features of the
13 present inadequacies and that health care programs must be
14 extended to provide universal coverage. The Pool knows
15 that many farmers are excluded from existing pre-payment
16 plans because they live under isolated conditions, that
17 some are excluded because they are older than age limits
18 set by existing plans and that some are excluded because
19 they may be considered poor health risks. The Pool is
20 aware that individuals other than farmers are also excluded
21 from existing plans for exactly the same reasons. The Pool
22 believes that individual recipients should contribute to
23 the cost of health care. However, many individuals, some of
24 whom are farmers, are simply not able to pay and these
25 should not be denied any less benefit because of this
26 financial inability. The Pool's concern for the farmers
27 it represents is to promote availability of adequate health
28 care under terms that are equitable and not to debate the
29 methods by which this kind of facility and service is
30 financially possible. If this end can be accomplished



1 without resort to complete government control the Pool
2 would support a health care financing program of this order.
3 But if this end cannot be accomplished outside of complete
4 government control, and many members of the Pool suspect
5 this will be found to be the case, then the Pool would not
6 hesitate to support government control.

7 In conclusion, Saskatchewan Wheat Pool
8 submits in summary two main points, both of specific con-
9 cern to farmers. The first is that increased effort must be
10 made to provide health care services and facilities for the
11 resident of Saskatchewan's farms on a basis reasonably com-
12 parable to service and facilities available to urban
13 citizens. The second is that some method must be found and
14 made operative to give farmers equal opportunity to budget
15 in advance for health care services. Those unable to pay,
16 both on the farm and in the towns, must not be denied
17 adequate services and facilities for health care.

18 COMMISSIONER FIRESTONE: Mr. Boileau, does
19 the Saskatchewan Wheat Pool support the health care plan
20 as presently being put into effect by the Saskatchewan
21 Government?

22 MR. BOILEAU: Mr. Chairman, and Mr. Commis-
23 sioner, the Saskatchewan Wheat Pool policies are always
24 formulated by its membership, represented by its delegates.
25 The question you ask me, sir, has not been submitted to
26 our delegate body, and as an organisation we are not in a
27 position to state definitely an answer to your question.

28 COMMISSIONER FIRESTONE: I take it this matter
29 will be considered?

30 MR. BOILEAU: I presume so, sir, at our next



...and cannot be accomplished on a basis of complete
government control, and many members of the pool would
this will be found to be the case, then the pool would
be unable to support government control.

In conclusion, Saskatchewan Wheat Pool
...in many two part points, both of specific con-
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made to provide health care services and facilities for the
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MR. BOLLEA: Mr. Chairman, and Mr. ...
...the Saskatchewan Wheat Pool policies are always
...by its membership, represented by its delegates
...the question you ask me, has not been submitted to
...position to state definitively an answer to your question.

...be considered?
MR. BOLLEA: I presume so, sir, as our re



1 annual meeting.

2 COMMISSIONER FIRESTONE: When will that
3 annual meeting take place?

4 MR. BOILEAU: November, 1962.

5 COMMISSIONER FIRESTONE: Would you feel that
6 in view of the fact that this matter has not been discussed
7 by all the, say, executive members of the Wheat Pool that it
8 would be difficult for you to offer us any comments on some
9 of the implications of this programme including such sug-
10 gestions as the proposal that has been put before us that
11 the Federal Government should contribute to such a medical
12 care programme in Saskatchewan as part of a national
13 programme? Would you feel you would not be in a position
14 to deal with questions of this nature because you have had
15 no opportunity for consultation and advice?

16 MR. BOILEAU: I would like to answer in this
17 manner: The Pool has in the past advocated universal medi-
18 cal care. We have not planned or resolved just how this shou
19 be provided, but we have advocated universal medical care.

20 COMMISSIONER FIRESTONE: And if we under-
21 stand you correctly, you have suggested that you would have
22 no objection in introducing such a program on a compulsory
23 basis if this was the effective way of covering all the
24 rural population of Saskatchewan?

25 MR. BOILEAU: We have said if it could not
26 be done otherwise we would support a government operated
27 plan.

28 COMMISSIONER FIRESTONE: Now, we have a
29 government operated plan in the process of being put into
30 operation in Saskatchewan and the point has been made to

annual meeting have place?

Q. Now, would you feel that

in view of the fact that this matter has not been discussed

position as the proposal has been put before us that

the Federal Government should contribute to such a medical

care program in Saskatchewan as part of a national

program? Would you feel you would not be in a position

to deal with questions of this nature because you have had

no opportunity for consultation and advice?

A. Yes, I would like to answer in this

manner. The fact is that the past government universal medical

care plan, we have not planned or received just now that should

be provided, and we have submitted universal medical care

to the Minister of Health. And if we understand

what you are saying, you have suggested that you would have

no objection in introducing such a program on a compulsory

basis. Is this the effective way of covering all the

medical population of Saskatchewan?

A. Yes, we have said it is a valid one

because otherwise we would support a government sponsored

plan

Q. Now, would you feel that

government operated plan in the process of being put into

operation in Saskatchewan and the point has been made to



1 this Commission that it would be considered appropriate
2 for the Federal Government to contribute to such a plan
3 up to, say, such a proportion as sixty per cent of the
4 cost of such a plan as part of the national program. Would
5 you feel that the Federal contribution to a Provincial plan
6 would be a desirable objective or approach?

7 MR. BOILEAU: I would feel that a comprehen-
8 sive plan in the Province of Saskatchewan would be most
9 difficult to operate without Federal assistance.

10 COMMISSIONER FIRESTONE: In other words, you
11 are in favour of the principle of a Federal contribution
12 although you do not hold a specific belief whether it
13 should be 50 or 60%. Am I right in that understanding?

14 MR. BOILEAU: You are right.

15 COMMISSIONER FIRESTONE: Now, if the Federal
16 Government was to make a contribution in accordance with
17 what you consider equitable, this may involve increases of
18 taxes or income tax. Would you say the Saskatchewan Wheat
19 Pool and its members would support such increases in income
20 tax to pay for this Federal contribution? You realize,
21 anything the Government gives out has to be collected some-
22 where.

23 MR. BOILEAU: It first has to take.

24 COMMISSIONER FIRESTONE: That is correct.
25 So, would you feel your Pool and its members would uphold
26 such an increase?

27 MR. BOILEAU: If we as individuals or as
28 organizations accept or ask for greater services from
29 senior government, from others than ourselves, we must be
30 prepared to pay. This is probably unofficial as far as the



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cost of such a plan as part of the national program. Would
you feel that the Federal contribution to a provincial plan
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although you do not hold a specific belief whether it
should be 50 or 60%. Am I right in that understanding?

MR. BOLLEA: You are right.
COMMISSIONER WILSON: Now, if the Federal

must you consider carefully, this may involve increases of
taxes or income tax. Would you say the Saskatchewan Wheat
Pool and its members would support such increases in income
tax to pay for this Federal contribution? You realize
saying the Government gives out has to be collected some-

MR. BOLLEA: It is not too far.
COMMISSIONER WILSON: That is correct.

So, would you feel your Pool and its members would uphold
such an increase?

MR. BOLLEA: If we are individuals or as
organizations accept or ask for greater services from
senior Government, from others than ourselves, we must be
prepared to pay. This is probably unorthodox as far as the



1 Pool is concerned but to be truthful with you I will have
2 to say if we are asked for more, we would assume more would
3 be taken from us. There would have to be an increase in
4 taxation.

5 COMMISSIONER FIRESTONE: However, you feel
6 your members would support an increase in tax to support
7 such a plan?

8 MR. BOILEAU: I do.

9 COMMISSIONER McCUTCHEON: You do not regard
10 government services as being free?

11 MR. BOILEAU: I would say I don't and I don't
12 think many people do.

13 COMMISSIONER FIRESTONE: A very appropriate
14 answer.

15 COMMISSIONER BALTZAN: Just this statement,
16 I do not think anybody can feel with you more in your very
17 splendid presentation than I can. As a boy on a farm in
18 Saskatchewan the nearest blacksmith extracted my tooth and
19 the nearest dentist was eighty miles away.

20 MR. BOILEAU: That is right, sir.

21 COMMISSIONER STRACHAN: Mr. Chairman, I
22 read one sentence on page 6:

23 "This demonstrates that the farmer on the
24 farm is at a disadvantage to the urban dweller in
25 availability of health care services."

26 Without being facetious, I am sure you
27 realize there cannot be a modern health institution provid-
28 ing the best health services in the front yard of every
29 farmer. How close and in what proximity do you feel these
30 institutions should be to the average farmer? Coupled with



1 that, may I ask what is the greatest distance at the
2 present time that the average farmer has to go to reach
3 hospital facilities?

4 MR. BOILEAU: Answering your first question:
5 We very definitely are of the opinion that the number of
6 doctors, and I would like to probably say general practition-
7 ers in the smaller towns, in the partially settled areas
8 of the Province are too few or much fewer than they were
9 twenty or twenty-five years ago. We very definitely cannot
10 hope for and cannot expect it would be reasonable that
11 complete facilities would be available within any reasonable
12 proximity of every farm. However, as the condition now
13 exists, many people in areas of this Province have to
14 travel long distances to get to what you might refer to
15 possibly as first-aid treatment or general treatment with-
16 out any reference to any specialist whatsoever. To be
17 specific, I am of the opinion that farm families should be
18 able to reach a medical doctor within one or two hours
19 travelling.

20 COMMISSIONER STRACHAN: In that connection,
21 I am sure you realize that the more you improve a medical
22 institution, hospital, the more personnel would be required
23 to run that institution and the fewer physicians you would
24 have in the surrounding area. Is that not reasonable? You
25 may have your farmers further than ever from the personal
26 services of a physician.

27 MR. BOILEAU: I do not quite follow that.

28 COMMISSIONER STRACHAN: As you would wish to
29 have modern health institutions providing the best health
30 services near to a farm you are going to increase those



...and I am sure it is the greatest blessing in the

present time that the average farmer has to go to reach

...the nearest hospital

MR. BOLLEAU: Answering your first question:

...we have a hospital at the present time at the present time

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COMMISSIONER SIRAGHAN: In that connection,

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have in the surrounding area. Is that not reasonable? You

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MR. BOLLEAU: I do not quite follow that.

COMMISSIONER SIRAGHAN: As you would wish to

have modern health institutions providing the best health

services near to a farm you are going to increase those



1 institutions in the Province?

2 MR. BOILEAU: Yes, you are.

3 COMMISSIONER STRACHAN: And to have those
4 institutions you would require a greater medical personnel
5 on all services?

6 MR. BOILEAU: Yes.

7 COMMISSIONER STRACHAN: Then would you not
8 be drawing that medical personnel from a larger area, in-
9 creasing the area where there are not any individual phy-
10 sicians?

11 MR. BOILEAU: You would probably have some
12 effect on decreasing the concentration of services in the
13 large urban centres. If more treatment or specialized
14 treatment was available in more locations than at the
15 present, probably it would decrease the number of persons
16 going to the large centres for these specialist services.

17 THE CHAIRMAN: Mr. Boileau, the Saskatchewan
18 Wheat Pool, as you have said, would like to see a compre-
19 hensive plan available to everybody in the Province?

20 MR. BOILEAU: Yes, sir.

21 THE CHAIRMAN: And whether it would be a
22 voluntary or compulsory thing is left as an open question?

23 MR. BOILEAU: Yes.

24 THE CHAIRMAN: Now, would you care to ex-
25 press an opinion on this: An effective plan, whether it
26 is voluntary or compulsory, how do you visualize such a
27 plan helping the isolated farmer?

28 MR. BOILEAU: Only in this manner, Mr. Chair-
29 man, that a plan which would provide them with services,
30 would be available when required.



COMMISSIONER STRACHAN: And to have those
institutions that would require a greater medical personnel
on all services?

MR. POLLEAU: Yes.
COMMISSIONER STRACHAN: Then would you not
be drawing that medical personnel from a larger area, in-
creasing the area where there are not any individual phy-
sicians?

MR. POLLEAU: You would probably have some
effect on decreasing the concentration of services in the
large urban centers. It more treatment or specialized
treatment was available in more locations than at the
present, probably it would decrease the number of persons
going to the large centers for these specialist services.
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hensive plan available to everybody in the Province?

MR. POLLEAU: Yes, sir.
THE CHAIRMAN: And whether it would be a
voluntary or compulsory thing is left as an open question?
MR. POLLEAU: Yes.

THE CHAIRMAN: Now, would you care to ex-
press an opinion on this: An effective plan, whether it
is voluntary or compulsory, how do you visualize such a
plan, that a plan which would provide them with services,
would be available when required.



1 THE CHAIRMAN: I do not want to interrupt
2 you, but would you mind saying what you mean by that?
3 Do you anticipate any plan is going to create a greater
4 body of physicians in the Province?

5 MR. BOILEAU: Well, we would hope that a
6 plan would make it more possible or more attractive to
7 physicians to remain in the smaller towns in strictly rural
8 areas.

9 THE CHAIRMAN: What do you say that a plan
10 could be that would do that?

11 MR. BOILEAU: Well, a plan to do that would
12 probably assure a physician in an isolated country town a
13 continuous reasonable income; probably provide him with
14 some facilities at his location which he himself or the
15 area does not provide for him; probably provide him with a
16 mobile specialist or consultant who would visit him occas-
17 ionally to make his work a little easier and some more
18 assurance that he is part and parcel of the health services.

19 THE CHAIRMAN: Thank you very much, Mr.
20 Boileau. We are grateful to the Saskatchewan Wheat Pool.
21 We know the extent and the magnitude of the coverage that
22 the Pool has throughout the Province and it is felt on this
23 regional basis of representation from almost the individual
24 farm up. And, therefore, the views which you have expressed
25 on behalf of so many people will receive the due considera-
26 tion of this Commission.

27 MR. BOILEAU: Thank you very much, Mr.
28 Chairman, for giving us this opportunity.

29 THE CHAIRMAN: We will take a short recess
30 and then proceed with the College of Dental Surgeons.



THE CHAIRMAN: I do not want to inter-

pose, but would you mind saying what you mean by that?

Do you anticipate any plan is going to create a greater

body of physicians in the locality?

MR. TOLSON: Well, we would hope that a

plan would make it more possible for more attractive to

physicians to remain in the smaller towns in steadily rural

areas.

It could be that, would do that.

MR. TOLSON: Well, a plan to do that?

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continuous relationship in that, probably provide him with

some facilities at his location which he himself or the

area does not provide for him, probably provide him with a

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available, but he is not a part of the health ser-

vice, we are going to have some other things, Pool.

It is not the extent and the magnitude of the coverage that

the Pool has throughout the Province and it is felt on this

regional basis of representation from almost the mid-west

to the east. And, therefore, the thing which you have expressed

on behalf of so many people will receive the due considera-

tion of this Commission.

MR. TOLSON: Thank you very much, Mr.

Chairman, for giving me this opportunity.

MR. TOLSON: We will take a short recess

and then proceed with the College of Dental Surgeons.



SUBMISSION OF

THE COLLEGE OF DENTAL SURGEONS OF SASKATCHEWAN

APPEARANCES:

DR. J.P. WHYTE
DR. W.F. HANCOCK
DR. R.O. BRETT
DR. D.M. PARKER
DR. E.N.F. JENKINS
DR. F.S. GREEN

THE CHAIRMAN: Will you now come to order

and we will proceed with the submission from the College
of Dental Surgeons of Saskatchewan.

THE SECRETARY: That will be Exhibit number
104.

---EXHIBIT NO. 104: Submission of Dental Surgeons
of Saskatchewan.

THE CHAIRMAN: Who is the spokesman?

MR. GREEN: Mr. Chairman, it is my privilege
to present to the Commission the members of the Saskatchewan
College of Dental Surgeons. I am Dr. Green of North Battle-
ford and the Vice-President of the College. Other members
here are on the council of the College which is the govern-
ing body of the College. Dr. Jenkins of Estevan and Dr.
Parker of Regina. I would also like to present to you Dr.
Whyte of Swift Current. Dr. Whyte is past President of the
Canadian Dental Association, Vice-President of the Saskat-
chewan College of Dental Surgeons and has served on the
Council of the College for eight years. He also was a
member of the Board of Governors of the Canadian Dental
College for ten years. I would present Dr. Hancock of
Fort Qu'Appelle who is at present President of the National



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are on the committee of the College which is the govern-
ing body of the College. Dr. Jenkins of Estevan and Dr.
Fisher of Regina. I would also like to present to you Dr.
Wright of Swift Current. Dr. Wright is past President of the
Canadian Dental Association, Vice-President of the Saskat-
chewan College of Dental Surgeons and has served on the
Council of the College for eight years. He also was a
member of the Board of Governors of the Canadian Dental
College for ten years. I would present Dr. Hancock of
North Battleford who is at present President of the National



1 Dental examining Board and has been a member of that Board
2 for ten years. He is also Vice-President of the Council
3 of the College and has served on the Council for eight
4 years.

5 We also have here Dr. Brett of Regina who
6 is Vice-President of the Saskatchewan College of Dental
7 Surgeons and has served six years on Council. He is also
8 our appointee to the Senate of the University of Saskatchewan.
9 Dr. Brett has been chosen to be our spokesman for the Brief
10 and our recommendations and any discussion.

11 DR. BRETT: Mr. Chairman and Members of
12 the Commission, the College of Dental Surgeons of Saskat-
13 chewan thanks the Government of Canada for establishing
14 the Royal Commission on Health Services. A thorough exami-
15 nation of the problems of providing medical and dental
16 care to the people is a worthwhile endeavour. The College
17 gives its assurance that it will co-operate in any way
18 possible to improve the dental health of the Saskatchewan
19 people.

20 May I start on page 5 of the Brief.

21 Dental disease is rampant across Canada.
22 Tooth Decay has been seen in one-year old children and by
23 age 19, 99 per cent of the population has suffered some
24 type of dental disorder. Despite these appalling facts,
25 only a minority of the families make even one visit a year
26 to a dentist. In Saskatchewan during 1960, it is likely
27 that no more than 28 per cent of the population will visit
28 a dentist for even the most minor type of treatment.

29 Many reasons can be cited why the amount of
30 dental care received does not nearly equal the amount



1 considered necessary for good dental health. These reasons
2 can be divided into two main categories:

3 factors which prevent people from seeking
4 dental services;

5 factors which prevent dentists from supplying
6 the volume of services actually required.

7 If I may interject, people who do know the
8 proper oral hygiene and dietary habits, even these people
9 do not use this knowledge to the best advantage.

10 WHY ARE DENTAL SERVICES IN SHORT SUPPLY?

11 Essentially, there just are not enough
12 dentists in Saskatchewan. Only two Canadian provinces have
13 greater shortages in the number of dentists per population.
14 Saskatchewan has 5,000 people for each practising dentist.
15 The ratio is much worse in rural (8,335) than in urban
16 centres (2,442). And the situation is getting worse.

17 In the past ten years the population of
18 Saskatchewan has increased 9 per cent. The number of den-
19 tists has dropped 7 per cent. Since 1955, newly graduated
20 dentists and immigrants have barely compensated for the
21 number of dentists leaving the province. In addition,
22 Saskatchewan dentists have a higher death and retirement
23 rate than Canada as a whole. With the large percentage of
24 dentists between 60 and 64 (14 per cent) compared with the
25 small number under 30 (4 per cent) the prospect is, to say
26 the least, discouraging.

27 The number of Saskatchewan residents enter-
28 ing dental colleges in Canada and the United States compares
29 very favourably with the records for other provinces.

30 During the 1959-1960 term, for example, Saskatchewan was



1 the third province in Canada in the number of dental
2 students it had in relation to its population; and, if I
3 may interject, this is partly a result of our recruitment
4 program which has been carried out by the College, and the
5 individual dentist on his own. But many of these students
6 are not returning to the province to open practices. They
7 give several reasons for not doing so:

- 8 1. There are many small centres in Saskatchewan
9 which have never had a dentist and where the
10 need for dental care is great, but it is
11 difficult for the individual dentist to
12 gauge whether the demand for his services
13 will be large enough to support a dental
14 practice.
- 15 2. It is often difficult to find suitable office
16 facilities in towns and villages.
- 17 3. The distance from their colleagues and from
18 post-graduate courses makes further formal
19 and informal education in dentistry difficult
20 and much more expensive.
- 21 4. Professional and personal associations are
22 established in other provinces where the
23 student receives his dental education.
- 24 5. There is a feeling of uncertainty as to what
25 the conditions of practice in the province
26 may be in the future.

27 And maybe the sixth reason would be that
28 when the dental student is graduating he is also of marital
29 age, and some young lady has likely a ring on her finger,
30 and he is apt to stay in that location where his bride is.



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28 when the dental student is graduating he is also of marriage

29 age, and some young lady has likely a ring on her finger,

30 and he is apt to stay in that location where his bride is



1 WHY IS THE DEMAND FOR DENTAL SERVICES LESS THAN THE NEED?

2
3 Part of the answer to this question is in
4 the comparison of the number of visits to dentists by various
5 groups of people. For example, members of high income
6 families average over three times as many dental visits as
7 members of low income families. Also, people with more
8 education receive more dental care than people with little
9 education. It is also true that urban residents receive
10 more dental care than people from rural areas.

11 An American survey has shown that, among
12 low income groups, families whose head had nine or more
13 years of education made twice as many visits to the dentist
14 as did less well educated families. In the group with less
15 education, higher income families had twice as many dental
16 appointments as low income families. Lack of money appears
17 to have particular significance in preventing people from
18 visiting a dentist when the need for treatment is evident.
19 Childhood habits and knowledge of dental hygiene are most
20 important in inducing people to seek preventive care.

21 It is apparent, then, that lack of money is
22 not the only reason why people do not seek dental services.
23 Lack of appreciation of the value of dental services is a
24 very significant reason. Indifference and fear keep people
25 away from dental offices regardless of income.

26 Nevertheless some progress is being made in
27 overcoming indifference and economic barriers. While there
28 is no voluntary insurance plan for dental care in Saskat-
29 chewan, free dental care is being provided for some segments
30 of the population. The Swift Current and Assiniboia health
regions operate dental programs for children up to 12 years



1 of age, and the provincial government provides a broad
2 range of dental benefits for public assistance recipients.
3 Traditionally, individual dentists have provided much free
4 treatment in cases of real need. As a first organized step
5 in the direction of overcoming financial barriers, the
6 dental profession in Saskatchewan was the first in Canada
7 to inaugurate a postpayment plan. Under this plan, patients
8 can pay for treatment in instalments. This plan has since
9 spread to many other provinces.

10 If I may, sir, I would like to turn to our
11 recommendations, on page 4.

12 This brief is divided into several subjects.
13 Recommendations are included with the factual material for
14 each subject. For the sake of clarity and brevity, these
15 recommendations are summarized here. These recommendations
16 are explained in detail from page 8 to page 15.

17 To increase the supply of dental services
18 in Saskatchewan, the College recommends that:

19 1. A faculty of dentistry be established at the
20 University of Saskatchewan.

21 This is the first and the most important of
22 our recommendations.

23 2. The present program of bursaries for dental
24 students be extended and increased.

25 3. Vocational guidance programs in the schools
26 endeavour to acquaint more high school student
27 with the advantages of dentistry as a career.

28 4. An active recruiting program be launched to
29 encourage more dentists to settle in rural
30 Saskatchewan.



range of dental benefits for public assistance recipients.
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can pay for treatment in installments. This plan has since
spread to many other provinces.

If I may, sir, I would like to turn to the
recommendations on page 4.
This plan is divided into several sub-
recommendations and are grouped with the financial material to
each subject. For the sake of clarity and brevity, these
recommendations are summarized here. These recommendations
are explained in detail from page 8 to page 17.

To increase the supply of dental services
in Saskatchewan, the following recommendations are:

1. A faculty of dentistry be established at the
University of Saskatchewan.
This is the first, and the most important of
our recommendations.
2. The present program of courses for dental
students be extended and increased.
3. Vocational guidance programs in the schools.
4. An active recruiting program be launched to
encourage more dentists to serve in rural
Saskatchewan.



- 1 5. More financial assistance be given to post-
- 2 graduate clinics and seminars for dentists
- 3 in the province.
- 4 6. Dental services be provided in hospitals.
- 5 7. The fluoridation of municipal public water
- 6 supplies be facilitated in every way possible.
- 7 8. A new type of dental auxiliary be trained so
- 8 that the scope of services rendered by auxi-
- 9 liary personnel may be increased.

10 To make optimum use of the dental resources available in
11 Saskatchewan, the College further recommends that:

- 12 1. Programs of dental health education for
- 13 elementary school children be initiated in
- 14 each area as soon as the supply of personnel
- 15 makes this practicable.

16 We feel this is very important.

- 17 2. Use of T.V., Radio and Newspaper - impact on
- 18 preventive dentistry.
- 19 3. A program of prepaid dental services for
- 20 children be instituted.

21 Sir, I wish to stop at this point and leave
22 the rest of our time for questions, if I may.

23 THE CHAIRMAN: Thank you, Dr. Brett. I
24 wonder, in connection with your recommendation number 14
25 on page 4, programs of dental health education for elementary
26 school children. Are there any elementary school programs
27 in effect in Saskatchewan today?

28 DR. BRETT: Not as such, sir, although in
29 two health regions there is dental treatment being supplied
30 up to age twelve for school children in those areas, the



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2 graduate clinics and seminars for dentists
3 in the province.
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18 preventive dentistry.
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20 children be initiated.
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22 the rest of our time for questions, if I may.
23 THE CHAIRMAN: Thank you, Dr. Hertz, I
24 would in connection with your recommendation number 14
25 on page 4, programs of dental health education for elementary
26 school children, and there are elementary school programs
27 in effect in Saskatchewan today?
28 MR. HERTZ: Not as such, sir, although in
29 two health regions there is dental treatment being supplied
30 up to age twelve for school children in these areas, the



1 Assiniboia and Swift Current Regions.

2 THE CHAIRMAN: What is the situation in the
3 elementary schools in Saskatchewan at the moment?

4 DR. BRETT: This is being carried out as,
5 shall we say, the dentist volunteers his time, and on a
6 rotation basis they go into the public schools and do an
7 examination, and a report is sent home to the parents.

8 THE CHAIRMAN: When was the project which
9 was initiated by Dr. Hazelton when he was the first dentist
10 to hold the appointment, and which went on for a considerable
11 number of years, when was that discontinued?

12 DR. BRETT: It was a matter of finding per-
13 sonnel, sir. We have experienced this same thing in Regina.
14 Pre-war there were sufficient personnel, and there was a
15 school dental clinic run by the City, and similarly in
16 Saskatoon.

17 THE CHAIRMAN: It was run by the joint oper-
18 ation of the elementary school boards?

19 DR. BRETT: Yes, sir, and at war time, all
20 dentists were pressed into service, and on return didn't
21 settle in Saskatchewan in the same proportion as other
22 provinces.

23 THE CHAIRMAN: That experiment in Saskatoon
24 ran for twelve to fifteen years at least. Was there ever
25 a compilation made of the effect realized from such a
26 program, because as you recall that was an organized and
27 universally applied program to all the children in all the
28 elementary schools from the ages of 1 to 8. There must be
29 some studies available of that, I am sure.

30 COMMISSIONER STRACHAN: Mr. Chairman, may I

elementary schools in Saskatchewan at the moment?

shall we say, the dentist visits him his time, and on a
rotation basis they go into the public schools and do an
examination, and a report is sent home to the parents.
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was initiated by Dr. Haseleton when he was the first dentist
to hold the appointment, and which went on for a considerable
number of years, when was that discontinued?

DR. HASELETON: It was a matter of finding per-
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Formerly there were sufficient personnel, and there was a
school dental clinic run by the city, and similarly in
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program, because as you recall that was an organized and
universally applied program to all the children in all the
elementary schools from the ages of 1 to 8. There must be
some studies available of that, I am sure.

COMPTROLLER STEPHAN: Mr. Chairman, may I



1 suggest that you instruct Dr. Brett and the others at the
2 table that they are all free to answer, and any other
3 members, and people in the audience.

4 ~~Brett, and the~~ THE CHAIRMAN: Oh, yes.

5 ~~if you will~~ DR. HANCOCK: As a member of the staff of
6 the Regina School Dental Clinic, 25 years ago our program
7 consisted of treatment and dental health education. The
8 dental health education was handled at that time by the
9 public school nurse, and our dental staff. Along with the
10 education, treatment services were provided, and examination
11 services were provided for all children in the public schools
12 Compilation of results, the actual figures I don't think
13 I can tell you, but they do have them in Toronto.

14 ~~by the process~~ THE CHAIRMAN: Could your Association obtain
15 for us the statistical data that may be available in
16 respect of both the Regina program and the Saskatoon pro-
17 gram, because from my knowledge they are probably two of
18 the best developed programs perhaps in Canada over a suf-
19 ficiently long period of years to have produced some
20 statistics of value.

21 DR. HANCOCK: Mr. Chairman, Toronto has had
22 one for the last thirty-five years, mainly based on the
23 treatment rather than on education. We feel that more
24 education and less treatment is the correct answer.

25 ~~see that well~~ THE CHAIRMAN: That well may be. I just
26 want to know if you can get us this information?

27 ~~see that well~~ DR. HANCOCK: We will certainly try, sir.

28 ~~see that well~~ DR. BRETT: I will see that this is forwarded
29 to you.

30 ~~see that well~~ THE CHAIRMAN: I don't want to be involved



table that they are all free to answer, and any other members, and people in the audience.

DR. HANCOCK: As a member of the staff of the Regina School Dental Clinic, 25 years ago our program consisted of treatment and dental health education. Dental health education was handled at that time by the public school nurse, and my dental staff. Along with the services were provided for all children in the public schools. Cooperation of dentists, the dental hygienists I don't think I can tell you, but they do have them in Toronto.

THE CHAIRMAN: Could your Association obtain for as the statistical data that may be available in respect of both the Regina program and the Saskatoon program, because from my knowledge they are probably two of the best developed programs perhaps in Canada over a 25-year period of time.

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THE CHAIRMAN: That will may be. I just want to know if you can get us this information? DR. HANCOCK: We will certainly try, sir. DR. BROWN: I will see that this is forwarded. THE CHAIRMAN: I don't want to be involved



1 in any discussion --

2 DR. BRETT: I will do that, sir.

3 THE CHAIRMAN: Thank you very much, Dr.

4 Brett, and when it is available, and if it is available
5 if you will forward it to our Secretary at our office in
6 Ottawa.

7 COMMISSIONER GIRARD: Dr. Brett, in view of
8 the extreme shortage of dentists that you seem to have,
9 have you ever thought of attracting young women into the
10 profession?

11 DR. BRETT: Well now, in the program as set
12 up in the schools for counselling for their future vocations,
13 the girls do sit in on this. I know that there are three
14 in the profession now in Toronto in the graduating class.

15 THE CHAIRMAN: There is one practising
16 dentist in Melfort, Dr. Connell.

17 DR. BRETT: Yes, there is another in Prince
18 Albert, but I think the question is why aren't we attracting
19 more of them.

20 COMMISSIONER GIRARD: Yes?

21 DR. BRETT: I think they fall by the wayside
22 into matrimony before they complete their course.

23 COMMISSIONER GIRARD: Would there be one
24 angle you could use, maybe to try to attract them? I could
25 see very well that they would be very efficient in school
26 children programs for instance, and if that were brought
27 out in your campaigns, maybe they might not visualize this,
28 they might think of themselves trying to extract a tooth
29 to a great big man, and they might not think that they
30 would be able to do this.



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2 IR. BRETT: I will be that, sir.

3 THE CHAIRMAN: Thank you very much, Dr.

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5 it you will forward it to our Secretary at our office in
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15 dentist in Melton, Dr. Cornell.

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17 Albert, but I think the question is why aren't we attracting
18 more of them.

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24 see very well that they would be very efficient in school
25 children programs for instance, and if that were brought
26 out in your campaigns, maybe they might not visualize this
27 they might think of themselves trying to extract a lesson
28 to a great big man, and they might not think that they
29 would be able to do this.



1 DR. BRETT: I agree a sixteen or seventeen
2 year old girl is thinking of working for children. I know
3 my own said that she wanted to be in something working
4 with children.

5 DR. WHYTE: In 1960, graduating from Canadian
6 universities there were seven women, and also on the
7 recruitment, the Canadian Dental Association have set up a
8 very active Committee on Recruitment with sub-committees
9 in each province, and strangely enough, for some reason we
10 do not seem to be able to attract the women. The ladies
11 don't seem to be attracted to dentistry, not by any means,
12 as much as the men.

13 COMMISSIONER GIRARD: Maybe you didn't try
14 hard enough?

15 DR. BRETT: There is a program for dental
16 hygienists, and I do think that the team approach with the
17 child going to the hygienist fulfills this work with chil-
18 dren and is much more attractive to a girl who only wants
19 to spend two or three years before getting married. It
20 may work out that way, directing it towards dental hygien-
21 ists, rather than dentistry ourselves unconsciously.

22 COMMISSIONER BALTZAN: Gentlemen, I have no
23 questions. I want to thank you for much valuable informa-
24 tion and new knowledge about your problems.

25 THE CHAIRMAN: Dr. Brett, and you may ask
26 anyone to answer this as you see fit, in this matter of
27 recruitment and the suggested difficulties of getting
28 sufficient personnel, there is mention of bursaries, or
29 loans, or scholarships. Have you an opinion to express on
30 the so-called conditional bursaries?

Mr. BROWN: I agree a little of seventeen

year old girl is thinking of working for children. I know

Dr. WHEAT: In 1960, graduating from Canada

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very active committee on recruitment with a committee

in each province, and already enough. For some reason we

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child going to the pediatric dentist's work with child-

dent and is much more attractive to a girl who only wants

to spend two or three years before getting married. If

may work out that way, otherwise it's a very real problem

later, rather than dentistry ourselves immediately.

COMMISSIONER BROWN: General, I have no

questions. I want to thank you for your valuable informa-

tion and new knowledge about your problem.

THE CHAIRMAN: Mr. Brown, and you may ask

anyone to answer this as you see fit, in this matter of

recruitment and the suggested difficulties of getting

sufficient personnel, there is mention of hospitals, or

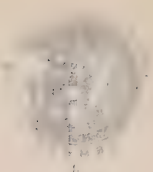
schools, or scholarships. Have you an opinion to express on



1 DR. WHYTE: The bursary situation in
2 Saskatchewan is a very minimum effort at the present time.
3 Saskatchewan maintains four one thousand dollar bursaries
4 for dental students in their last dental year, in return
5 for which these students promise to return to designated
6 rural areas. That is, not all rural areas, the only pre-
7 clusion is the City of Saskatoon, Regina, Moose Jaw, and
8 Prince Albert, and that amount of a thousand dollars, of
9 course, is not repayable. We have very definitely suggestion
10 and ideas on these bursaries.

11 THE CHAIRMAN: We would be very glad to have
12 them.

13 DR. WHYTE: We feel that the bursary situa-
14 tion should be more on the basis, and possibly maybe entail
15 the co-operation of the Federal Government. Everybody
16 seems to be going there, and it is hardly fair. We feel
17 that these bursaries, as far as Saskatchewan is concerned,
18 the availability of the future dental services of Saskat-
19 chewan depends on something very drastic being done to
20 bring dentists to our Province. Since 1938 to 1961, we
21 are the only Province who have less dentists than they had
22 before, and number two, that 25% of the dentists in
23 Saskatchewan are over 59 years of age. That is getting
24 close to the time when they should be retiring if they
25 don't. Then we have about fifty percent of the dentists
26 in Saskatchewan running at about forty-six years of age.
27 Well, even with all our younger men coming in we are
28 getting into a precarious position. We suggest in the
29 bursary situation that the bursary should be on the same
30 basis as the Royal Canadian Officers Training Plan: four



1
2 Saskatchewan is a very minimum effort at the present time.
3 Saskatchewan maintains four one thousand dollar nurseries
4 for dental students in their last dental year, in return
5 for which these students promise to return to designated
6 rural areas. That is, not all rural areas, the only pre-
7 scribed is the City of Saskatoon, Regina, Moose Jaw, and
8 Prince Albert, and that amount of a thousand dollars of
9 course, is not repayable. We have very definitely suggested
10 and ideas on these nurseries.
11 THE CHAIRMAN: We would be very glad to have
12
13 DR. WATKINS: We feel that the nursery situa-
14 tion should be more on the basis, and possibly cover areas
15 the co-operation of the Federal Government. Every day
16 seems to be going better and it is hardly fair, we feel
17 that these nurseries as far as Saskatchewan is concerned,
18 the availability of the dental services of Saska-
19 shewan depends on something very drastic being done to
20 bring dentists to our Province. Since 1955 to 1961, we
21 are the only Province who have less dentists than they had
22 before, and number two, that 90% of the dentists in
23 Saskatchewan are over 50 years of age. When we get
24 close to the time when they should be retiring, it is
25 doubtful. Then we have about fifty percent of the dentists
26 in Saskatchewan turning at about forty-five years of age
27 and, even with all our younger men coming in we are
28 getting into a precarious position. We suggest in the
29 primary situation that the nursery should be on the same



1 years dental service, books, tuition, living expenses,
2 etcetera. We also propose definitely -- and it is no use
3 coming to you with problems unless we offer a solution --
4 and the solution we offer is that for a period of five
5 years let the government take ten recruits from Saskat-
6 chewan each year for five years and train them for their
7 four dental years, and in return they pay half of their
8 expenses back. It is calculated that an education in
9 dentistry is \$6,141.69, but I think we would have to make
10 that about \$6,500.00; and they would get that just periodi-
11 cally -- each year. That is something specific that we
12 recommend -- a five-year plan, ten a year. In other words,
13 we would get fifty dentists to look after death and retire-
14 ment and the increase of population which we hope Saskat-
15 chewan will have.

16 THE CHAIRMAN: Do you think the prospects
17 will accept the condition of coming back? They will pro-
18 bably be quite willing to accept the offer of the education,
19 but it is the condition of returning?

20 DR. WHYTE: That, sir, is a very good ques-
21 tion, and the answer I give is that there must be a lot of
22 personal application put into the situation. If we want
23 in Swift Current a dentist, I have to go and get two boys
24 who are going to come back to Swift Current in return for
25 what they get. The same for Shelbrooke or Estevan or any
26 of the other small towns of Saskatchewan. Our distribution
27 of dentists is reasonable in Regina, Saskatoon and Prince
28 Albert, but in the smaller cities it is bad.

29 THE CHAIRMAN: Have you got any suggestions
30 to offer as to how you would ensure the return and the



1 years dental service, books, tuition, living expenses,
We also propose definitely -- and it is no use
coming to you with problems unless we offer a solution --
and the solution we offer is that for a period of five
years let the government take ten percent from each
crewman each year for five years and train them for their
four central years, and in return they pay half of their
expenses back. It is calculated that an education in
dentistry is \$6,000, but I think we would have to make
that about \$500.00; and they would get that just period-
ically -- each year. That is something specific that we
recommend -- a five-year plan, ten a year. In other words
we would get fifty dentists to look after health and rehabil-
ment and the increase of population which we hope Saskat-
chewan will have.
THE CHAIRMAN: Do you think the provinces
will accept the condition of coming back? They will pro-
bably be quite willing to accept the idea of the education
but it is the condition of returning?
DR. WYLLIE: That, also, is a very good ques-
tion, and the answer I give is that there must be a lot of
personal application put into the solution. If we want
to have a dentistry, I have to go and get two boys
who are going to come back so that I can get to return for
when they get. The same for the other professions or labor or any
of the other small towns of Saskatchewan. Our distribution
of dentists is reasonable in Regina, Saskatoon and Prince
Albert, but in the smaller cities it is not.
THE CHAIRMAN: Have you got any suggestions
to offer as to how you would ensure the return and the



1 staying of those which the Province would educate?

2 DR. WHYTE: I think the only insurance would
3 get back to the old thing of individual responsibility and
4 selecting the right type.

5 THE CHAIRMAN: You might make some mistakes?

6 DR. WHYTE: Yes, sir, you might have to be
7 prepared for a certain casualty situation. I know one
8 dentist in Saskatchewan who has already influenced five
9 boys. He has three away now, and two coming up in grade
10 twelve and one more in grade eleven. If one man can do
11 that, surely a hundred and sixty men can do something.

12 THE CHAIRMAN: For yourselves?

13 DR. WHYTE: Yes.

14 DR. BRETT: It is moral obligation more
15 than anything else. It is the only way we can tie them
16 up.

17 COMMISSIONER STRACHAN: Referring to your
18 first recommendation, has the dental profession made any
19 efforts to establish a dental school in Saskatchewan, and,
20 if so, what have been the efforts and the results?

21 DR. WHYTE: I suppose, Mr. Commissioner, I
22 will have to take that one, because I have been on the
23 Board the longest. Eighteen years ago the then Executive
24 of the Council of the Royal College of Dental Surgeons of
25 Saskatchewan made representations to the Government, but
26 that was not feasible, because you must have a medical
27 school if you are going to have a dental school. That was
28 not feasible, and nothing happened. Again in 1951, there
29 was a large health survey report and a commission on which
30 Dr. Hancock sat, and it sat for about two years, and brought



1 in a report that we have a dental school in 1951. Nothing
2 happened. Four years later there was a meeting held at
3 which the Presidents of the four western universities were
4 present and the Ministers of Health, and one of the first
5 items on the program was the dental school at Saskatoon,
6 and the decision then was that it was not feasible. Our
7 last effort has been in the Thompson Report brief which
8 we presented in 1961. In other words, as far as the
9 profession themselves are concerned, we have been pushing
10 for this through the years.

11 COMMISSIONER STRACHAN: You feel the profes-
12 sion has done all it possibly could in that connection?

13 DR. WHYTE: We have instituted our desire
14 and the fact that we think it should be done, and I think
15 we have done all we can, and we still are willing to do
16 more if and when the occasion arises.

17 COMMISSIONER STRACHAN: You will continue
18 your efforts?

19 DR. WHYTE: Yes.

20 THE CHAIRMAN: You spoke of your Brief to
21 the Thompson Committee. May that brief be made available
22 to this Commission?

23 DR. WHYTE: Yes, sir.

24 COMMISSIONER STRACHAN: If secondary school
25 students are encouraged to study dentistry, can they gain
26 admission to dental schools -- is there any difficulty in
27 that regard?

28 DR. HANCOCK: Mr. Commissioner, we have no
29 guarantee; although we have a good percentage of our
30 dental students in schools across Canada at the present time,



four years later there was a feeling here at
which the residents of the four western universities were
present and the Ministers of Health, and one of the items
on the program was the dental school at Saskatoon,
and the feeling was that it was not feasible. Our
last effort has been in the Thompson Report which
we presented in 1961. In other words, as far as the
proposition themselves are concerned, we have been waiting
for this kind of a venue.

DR. WHITE: You feel the problem
has not been done all in all in that connection.
DR. WHITE: We have mentioned our desire
and the fact that we think it should be done, and I think
we have done all we can, and we still are willing to do
more if and when the occasion arises.

COMMISSIONER STANLEY: You will continue
your efforts.

DR. WHITE: Yes.
THE CHAIRMAN: You spoke of your Board to
the program committee. May that panel be made available
to this committee?

DR. WHITE: Yes, sir.

students are encouraged to study dentistry and they gain
adaptation to dental schools -- is there any difficulty in
that regard?

DR. WHITE: No, Commissioner, we have no

question; although we have a good percentage of our
dental students in schools across Canada and the present



1 we have no guarantee we can keep that up. Each dental
2 school is under the control of a provincial government,
3 with the exception of McGill. That means if the province's
4 own boys cannot get into the school because of our boys
5 being in there, we are in danger of being excluded, although
6 the Deans of all universities have treated us very well,
7 but pressure may be put on them to educate their own boys.
8 Saskatchewan is unique in this, that they are the only
9 province that are not spending any money at all on dental
10 education. Right across Canada, Newfoundland and all the
11 Maritimes, are subscribing to the Dalhousie Medical School,
12 which they regard as a Maritime University. Quebec is
13 supporting the University of Montreal; Ontario, Toronto;
14 Manitoba, a new school built within the last few years;
15 Saskatchewan, nothing at all; Alberta has been supporting
16 a school since 1919; and British Columbia is in the
17 process of establishing a school. We are unique in a
18 strange way.

19 COMMISSIONER STRACHAN: Thank you very much
20 for bringing that in, because I had a question which I
21 hoped would bring that answer.

22 DR. HANCOCK: May I submit the figures for
23 Manitoba on the cost of a dental school?

24 THE CHAIRMAN: If you wish.

25 DR. HANCOCK: These are general figures and
26 they can be checked. We used Manitoba because their prob-
27 lem is about similar and we could use the number of grad-
28 uates they are graduating. They have nine or ten full-
29 time staff and forty-four part-time staff. Their capital
30 expenditure originally was \$2,500,000.00 to build the



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 with the exception of McGill. That means if the province
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 but pressure may be put on them to educate their own boys
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 province that are not spending any money at all on
 education. Right across Canada, Newfoundland and all the
 provinces, are contributing to the LaSalle Institute School
 which they regard as a Catholic University. Quebec is
 supporting the University of Montreal; Ontario, Toronto;
 a new school built within the last few years;
 Saskatchewan, nothing at all; Alberta has been supporting
 a school since 1911; and British Columbia is in the
 process of establishing a school. We are writing in a
 strange way.
 THE CHAIRMAN: Thank you very much.
 DR. HANCOCK: May I submit the figures for
 the cost of a dental school.
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 they can be checked. We used Manitoba because that prob-
 lem is about similar and we could use the number of grad-
 uates they are graduating. They have nine or ten full-
 time staff and forty-four part-time staff. Their capital
 expenditure originally was \$2,500,000.00 to build the



1 dental school in conjunction with the medical school.
2 Their operating expenditures per year are \$413,000.00.
3 Their income from clinics and from fees amount to much
4 less than \$100,000.00. So, the Province of Manitoba is
5 not only contributing in the capital, but is also contri-
6 buting that amount per year.

7 COMMISSIONER STRACHAN: One question I would
8 like to come to: Do you have trained auxiliaries in
9 Saskatchewan-- you state the need of auxiliaries.

10 DR. WHYTE: Yes, trained auxiliaries to the
11 extent of hygienists. We have seven in Saskatchewan four
12 of whom are employed by the Government and three in private
13 offices under supervision. I might add the University of
14 Toronto is still the only university training school for
15 hygienists and there are eight in the second year of
16 the course, and I am glad to say there are twenty-one in
17 the first year of the course in the University of Toronto.
18 In other words, we look as if we are getting an increased
19 interest in it.

20 DR. BRETT: Mr. Chairman, I would hate to do
21 this purposely, but I feel I should for the record: My
22 daughter is one of the people in that class, and there were
23 forty-six accepted, and I think there has been one dropped
24 out; forty-five in this present year.

25 DR. WHYTE: This is the 1960-61 I am speak-
26 ing of.

27 DR. BRETT: Yes, so this year they are up:
28 The maximum is sixty, and they have accepted forty-six.

29 COMMISSIONER STRACHAN: And the Commission
30 is aware there are eight in the first year in Dalhousie as



1 Their operating expenditures per year are \$113,000.00.
2 Their income from salaries and from fees amount to much
3 less than their operating expenditures.
4 not only contributing in the earliest, but in the latter
5 stages of the disease.
6 I would like to know the position of the
7 State to come to. Do you have limited facilities in
8 Saskatchewan - you have the need of facilities.
9 Yes, Mr. WATSON, yes, trained and facilities to the
10 extent of hospitals. We have seven in Saskatchewan, four
11 of whom are employed by the Government and three in private
12 offices under supervision. I might add the University of
13 Toronto is still the only university training school for
14 hygienists and there are eight in the second year of
15 the course, and I am glad to say there are twenty-two in
16 the first year of the course in the University of Toronto.
17 In other words, we look as if we are getting an increased
18 interest in it.
19 Yes, Mr. WATSON, yes, I think so, I would have to do
20 this purpose, but I don't know for the record.
21 daughter is one of the people in that class, and there were
22 forty-six accepted, and I think there has been one dropped.
23
24
25 Mr. WATSON: This is the first of the year.
26
27
28 The maximum is sixty, and they have accepted forty-six.
29
30 is aware there are eight in the first year in California.



1 well. You emphasized health education in your Brief pro-
2 vided personnel and facilities were available to you: Do
3 you think the provision of an abundance of money would
4 answer the dental problem?

5 DR. BRETT: Mr. Commissioner, if I may
6 answer that: Money is not the answer. It would help, but
7 where we have programs, where services are available to
8 social welfare groups and other similar groups, utilization
9 experience is rather low. In Alberta where they have had
10 a plan for a number of years -- at least twenty years --
11 they find the utilization, that the highest rate it has
12 ever been used is forty percent. In other words, sixty
13 percent, even though it is free, do not avail themselves of
14 the service for reasons known to themselves. In Manitoba
15 their experience, which is of a limited extent, is 19%
16 utilization instead of the more favourable one in Alberta,
17 which we, of course, think is very poor, even in Alberta.
18 So that dental health education, telling the people the
19 dangers of neglect and having them appreciate good dental
20 health is a very important aspect, and we feel it should
21 be started in the Department of Education, the teachers in
22 the schools, and trained auxiliaries and dentists. I am
23 sure the dentists would give of their time voluntarily to go
24 out and implement this dental health education which we
25 feel so strongly about.

26 COMMISSIONER STRACHAN: You refer to fluori-
27 dation in your recommendations: What has the dental profes-
28 sion done in furthering the introduction of fluoridation?

29 DR. PARKER: At the present time about 23%
30 of the population of this Province enjoys the benefit of



and facilities were available to you. Do
you think the provision of an abundance of money would

Mr. BRETT: Mr. Commissioner, if I may

answer that: Money is not the answer. It would help, but

where we have programs, where services are available to

social welfare groups and other similar groups, utilization

experience is rather low. In Alberta where they have had

a plan for a number of years -- at least twenty years --

they find the utilization, that the highest rate is that

ever been used is forty percent. In other words, sixty

percent, even though it is free, do not still themselves to

the service for reasons known to themselves. In Manitoba

their experience, which is of a limited extent, is low

utilization instead of the more favorable one in Alberta,

which we, of course, think is very poor, even in Alberta.

So that dental health education, telling the people the

dangers of neglect and having them appreciate good dental

health is a very important aspect, and we feel it should

be started in the Department of Education, the teachers in

the schools, and trained auxiliaries and dentists. I am

sure the dentists would give of their time voluntarily to go

out and implement this dental health education which we

feel so strongly about.

COMMISSIONER STACHAN: You refer to fluoridation

in your recommendations. What has the dental profes-

sion done in furthering the introduction of fluoridation?

Mr. TANN: At the present time about 25%

of the population of this Province enjoys the benefit of



1 fluoridated water. That compares fairly well with all
2 the other provinces except Manitoba. We have a total of
3 twenty-six towns having fluoridated water. Speaking from
4 personal experience, we have twice presented fluoridation
5 in a civic election. All the newspaper advertising and
6 radio advertising was paid for personally by the Regina
7 Dental Society. I regret to say we lost both times, but
8 we are quite willing to try again, and we have sent fre-
9 quent briefs to the Government urging them to make it as
10 easy as possible for a town to fluoridate their water.

11 Personally, I favour compulsory fluoridation by provincial
12 legislation. More than that, I don't know what we can do.

13 COMMISSIONER STRACHAN: Referring to this
14 extreme lack of personnel, and failing the establishment
15 of a dental school, is there anything else besides bursaries
16 which have been suggested that you would like investigated?

17 DR. BRETT: Mr. Chairman, we feel bursaries
18 should be given to hygienists as well. This was in effect
19 for three or four years and then was dropped. We feel these
20 should be reinstated and also make the bursary attractive
21 so that we may have more trained auxiliaries. A properly
22 trained auxiliary will enable the dentist to serve more
23 people and do more service and more work for the people of
24 Saskatchewan, and we feel that by auxiliaries we mean
25 hygienists and also any auxiliaries of the future. There
26 may be a few other types which will fit in with the
27 Canadian Dental Association's Brief on what they feel an
28 auxiliary should do and should not do. Basically we feel
29 that the more auxiliaries we get into the field and work
30 as a team with the dentists the more people can be looked
after.



Twenty-six towns having fluoridated water. Speaking from
personal experience, we have twice presented it in relation
to a civic election. All the newspaper advertising and
radio advertising was paid for personally by the Niagara
Dental Society. I regret to say we lost both times, but
we are quite willing to try again, and we have seen the
great benefit to the Government urging them to make it as
easy as possible for a town to fluoridate their water.
Personally, I favour compulsory fluoridation of municipal
water. Now when that, I don't know what we can do.
Some of the dentists are objecting to this
because of lack of personnel, and raising the establishment
of a dental school, is there anything else besides persuading
which have been suggested that you would like investigated?
Dr. PRATT, Mr. Chairman, we feel ourselves
should be given as much as well. This was in effect
for three or four years and then was dropped. We feel there
should be continued and also make the primary education
so that we may have more trained auxiliaries. I properly
trained auxiliary will enable the dentist to serve more
people and do more service and more work for the people of
Saskatchewan, and we feel that by auxiliary we mean
hygienists and also any assistants on the future. There
may be a few other types which will fit in with the
Canadian Dental Association's Board on what they feel as
auxiliary should do and should not do. Basically we feel
that the more auxiliaries we get into the field and work
as a team with the dentists the more people can be looked



1 And then, we have another suggestion that if we don't
2 get a dental school in the near future we should at least
3 have some dental offices in the hospitals in areas where
4 there is no service. Then, we feel that public health
5 education should be carried out immediately on as full a
6 scale as possible, and we feel compulsory fluoridation
7 would help solve the occurrence of decay which is at a very
8 high rate. Outside of these things we don't feel there
9 is anything else we can do to stimulate more entering
10 dentistry and solving our problem, except we need the
11 dental school.

12 COMMISSIONER STRACHAN: What is the situation
13 regarding dental clinics in the hospitals, and what effort
14 has the profession made to establish such clinics?

15 DR. HANCOCK: Dental clinics in the hospitals
16 there are some for the relief of pain and for surgery.
17 There is a dental clinic in the University Hospital in
18 Saskatoon for operative work on retarded children. Is that
19 what you want, or are you looking for country hospitals
20 with dental clinics attached?

21 COMMISSIONER STRACHAN: Either or both.

22 DR. HANCOCK: There are very few dental
23 clinics attached to the smaller units. It has been recom-
24 mended that a dental clinic be attached to the hospital,
25 but strangely it has run into a lot of local opposition
26 on the basis that the dentist attracts several people to
27 town, and they are not too fond of some people voting more
28 business to the next town. I ran into that in my own area.
29 But there are very few dental clinics in the Province of
30 Saskatchewan. Although they have been recommended by the



1 And then, we have another suggestion that if we don't
2 get a dental school in the near future we should at least
3 have some dental offices in the hospitals in areas where
4 there is no service. Now, we feel that public health
5 education should be carried out immediately on as wide a
6 scale as possible, and we feel compulsory fluoridation
7 would help solve the occurrence of decay which is at a very
8 high rate. Outside of these things we don't feel there
9 is anything else we can do to stimulate more activity
10 tentatively and solving our problem, except we need one
11 dental school.

12 COMMISSIONER STEWART: What is the situation
13 regarding dental clinics in the hospitals and what efforts
14 has the profession made to establish such clinics?
15 DR. HANCOCK: Dental clinics in the hospitals
16 there are some for the relief of pain and for surgery.
17 There is a dental clinic in the University Hospital in
18 Saskatoon for operative work on retarded children. Is that
19 what you want, or are you looking for country hospitals
20 with dental clinics attached?

21 COMMISSIONER STEWART: Either or both.
22 DR. HANCOCK: There are very few dental
23 clinics attached to the smaller units. It has been recom-
24 mended that a dental clinic be attached to the hospital.
25 But strangely it has not had a lot of local opposition
26 on the basis that the dentists already serve people in
27 town, and they are not too fond of some people visiting work
28 places to see the dentist. I ran into that in my own area.
29 But there are very few dental clinics in the Province of
30 Saskatchewan. Although they have been recommended by the



1 Government and all health authorities for the past several
2 years, very few of the small hospitals have dental clinics.

3 DR. BRETT: The space has all been allocated
4 to other purposes.

5 COMMISSIONER STRACHAN: Do you suggest there
6 has been space planned, but it fell by the wayside?

7 DR. BRETT: In the very early stages of the
8 building of small hospitals and the placement of the --
9 the head of the dental department was asked to draw up
10 what he felt was proper space for a dental clinic in a
11 hospital, and that is as far as it ever got, sir, to my
12 knowledge. It was left in the planning stage.

13 COMMISSIONER STRACHAN: I am back to the
14 matter of personnel: What about foreign graduates? Have
15 there been any great number?

16 DR. HANCOCK: We have a number of foreign
17 graduates practising in the Province now who passed our
18 Provincial Board. The foreign graduates supply is drying
19 up very rapidly, because the conditions of practice in the
20 old country must be much better than they were a few years
21 ago. We do have in the Province of Saskatchewan -- and I
22 hesitate to call them foreign; they are from other shores --
23 the English dentists who are accepted in Saskatchewan with
24 a B.D.S. degree and who write our examination right away.
25 We usually find the foreign graduate is under-trained and
26 unequal to our Canadian dentist, but there are a number in
27 the schools across Canada now of foreign graduates who are
28 taking their training commensurate with their abilities.
29 They are assessed by the universities and in one or two
30 years they are allowed to graduate, at which time, if they



years, very few of the small hospitals have been of clinical
DR. SMITH: The space has all been allocated

to be an out-patient.
COMMISSIONER STATION: To you suggest that

has been space planned, but it fell by the wayside?
DR. SMITH: In the very early stages of the

planning of small hospitals and the planning of the --
the head of the central department was asked to draw up

what he felt was proper space for a general clinic in a
hospital, and that is as far as it went, and then to say

knowledge, it was left in the planning stage.
COMMISSIONER STATION: I am back to the

matter of space: What have foreign graduates have
there been any great number?

DR. SMITH: We have a number of foreign
graduates practicing in the Province now, and I think of

Provincial level, the foreign graduates supply is growing
up very rapidly, because the number of graduates in the

and account that we have been that there were a few years
ago. We do have in the Province of Saskatchewan -- and I

notice to call them foreign, they are from other shores
the hospital service who are employed in Saskatchewan with

a B.C. degree and who work on examination right away.
We usually find the foreign graduate is under-trained and

proper to our Canadian center, but there are a number in
the school across Canada now of foreign graduates who are

They are assisted by the universities and in one or two
degrees, at which time, if they



1 write the Board Examinations and pass, they will be
2 accepted anywhere in Canada.

3 COMMISSIONER STRACHAN: Referring to your
4 last recommendation, number 16, it is quite understandable
5 that with your present personnel and facilities it would
6 be impossible to enter into a plan to provide dental ser-
7 vices on a broad scale: You advocate a program for chil-
8 dren; why do you recommend this program, and how would you
9 propose to implement it?

10 DR. WHYTE: Well, first, dental caries,
11 if there is ever going to be anything done in a manner
12 which will gradually disappear we have to start at the
13 bottom, we have to start with the children and we have to
14 start at an age of about three years and with a gradual
15 increase in the number of children looked after. In
16 Sweden, for instance, and other foreign countries of
17 Europe they have some very extensive childrens' programs.
18 Now, it is not our purpose today to say just how we would
19 do this in view of the fact that there is in Saskatchewan
20 a medical scheme going on. We do not know whether we are
21 going to be included in this or not other than the fact
22 that we wish to make it very clear that it is our policy
23 that any prepaid program for dentistry should not start at
24 the terminal end of dentures for those who are on pension.
25 We should spend all our money on those citizens who are
26 coming up. We want to make that our first policy. We do
27 not want to go into anything else other than the fact if
28 such a scheme is set up, there is one thing we would like,
29 and that is an administration board set up with one half
30 of the board appointed by the College of Dental Surgeons,



1 one-half appointed by the region or the Government and a
2 dentist sitting as chairman of that board. You see, with
3 lack of personnel and the situation we are in, it would be
4 futile for us to go into how to operate the thing. I
5 happen to come from the region where they have a setup
6 which at the present moment is doing some work and has
7 much to be desired in the full fulfillment of the plan
8 but they cannot help themselves, they have not got the
9 personnel, so there is not much use of us going on to
10 provide any specific plans which we are prepared to do if
11 and when we have the personnel to handle the situation.
12 That is our policy, we want that made clear that that is
13 our policy that any money spent for any prepaid plan in
14 dentistry in this Province should start with the children.
15 I am sorry I cannot go any further on that, but I think it
16 outlines our thinking.

17 COMMISSIONER STRACHAN: That is all I have
18 to ask. I do not know whether any of the other gentlemen
19 would like to express themselves on any point.

20 THE CHAIRMAN: Dr. Brett and gentlemen, your
21 Brief will receive consideration. I think I might tell you
22 that the subject of dentistry and the problems of the
23 dentists are receiving very special consideration. In the
24 research studies which we have commissioned dentistry
25 appears in three sections; we have undertaken a study of
26 dental education in Canada, by Dr. Paynter; a study in
27 the dental manpower requirements by Miss Boyd and in the
28 utilization of dentists by Dr. Oswald Hall of the University
29 of Toronto. In those three areas we are seeking to cover
30 the dental field and the subject of dentistry and its



1 ... of the Government and a
2 dentist sitting as chairman of that board. You see, with
3 ... of the Government and the ...
4 ... of the Government and the ...
5 ... of the Government and the ...
6 ... of the Government and the ...
7 ... of the Government and the ...
8 ... of the Government and the ...
9 personnel, so there is not much use of us going on to
10 provide any scientific plans which we are prepared to do it
11 and when we have the personnel to handle the situation
12 ... of the Government and the ...
13 our policy that any money spent for any special plan in
14 dentistry to take dentists should start with the children
15 ... of the Government and the ...
16 ... of the Government and the ...
17 ... of the Government and the ...
18 I do not know whether any of the other gentlemen
19 would like to express themselves on any point.
20 THE CHAIRMAN: In fact and gentlemen, you
21 ... of the Government and the ...
22 ... of the Government and the ...
23 ... of the Government and the ...
24 ... of the Government and the ...
25 ... of the Government and the ...
26 ... of the Government and the ...
27 ... of the Government and the ...
28 ... of the Government and the ...
29 ... of the Government and the ...
30 the dental field and the subject of dentistry and the



1 problems which are Canada-wide. They are getting as
2 special consideration as is possible time-wise and budget-
3 wise.

4 We are very grateful for your attendance
5 here today and the submissions you have made will go to
6 those three studying projects and to our own research
7 people and will have the consideration of the Commission.

8 DR. BRETT: Thank you very much, sir, for
9 your attention.

10 THE CHAIRMAN: Now, for the final matter
11 for today, we have the submission from St. Peter's Hospital
12 of Melville, Saskatchewan.

13 THE SECRETARY: Exhibit number 105.

14 ---EXHIBIT NO. 105: Submission of St. Peter's
15 Hospital.

16
17 S U B M I S S I O N O F
18 ST. PETER'S HOSPITAL

19 APPEARANCES:

20 SISTER JOSEPH LEONARD

21 SISTER MARY PETER

22 MR. W. SUTSKI

23 MR. P. DIELSCHNEIDER

24
25 THE CHAIRMAN: You are the spokesman, Mr.
26 Dielschneider?

27 MR. DIELSCHNEIDER: Yes, Mr. Chairman. We
28 have prepared a Brief and the Secretary has copies of it.
29 This is not perhaps so much recommendations or earth-shaking
30 suggestions for the Commission but it is statistical, it
give the background of our hospital which has been operated



1 since 1940 by the Order of St. Martha who operated on a
2 non-profit basis. Any earnings they presently obtain
3 through the Government Plan in operation in Saskatchewan
4 are put back into the building to meet expansion costs and
5 so on.

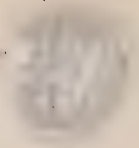
6 We have a recent problem particularly con-
7 cerning the extension of the two wings. We have completed
8 the wings, we opened them in June 1961, and the total cost
9 of this amounted to \$1,000,000.00, slightly over
10 \$1,000,000.00. We started out to raise a few hundred thous-
11 and dollars by way of donations and we received pledges of
12 \$115,000.00, but collected only \$84,000.00 to date. I
13 checked this morning with our campaign manager who is still
14 active, Mr. Watson who is the retired sheriff, and he ex-
15 pects to get another \$8,000.00. The funds for the extension
16 were raised by Federal and Provincial grants and our por-
17 tion of it was, I think, in excess of \$400,000.00. The
18 new formulae in operation takes care of the capital expen-
19 diture, the Sisters do have to pay the interest charges.

20 THE CHAIRMAN: The capital as it falls due
21 from year to year?

22 MR. DIELSCHNEIDER: Yes, but the interest
23 as it falls due from year to year is still paid for by the
24 salaries of the Sisters of St. Martha who just plough it
25 back in for that purpose. Any excess, if there is any,
26 could go into added facilities, but at the moment we are
27 still rather troubled as to whether there will be any.

28 THE CHAIRMAN: In addition to the salaries
29 there is 50% of the preferred accommodation?

30 MR. DIELSCHNEIDER: Yes. About the preferred



non-profit basis. Any earnings they presently obtain through the Government Plan in operation in Saskatchewan are put back into the building to meet expansion costs and so on.

We have a recent problem particularly concerning the extension of the two wings. We have completed the wings, we opened them in June 1961, and the total cost of this extension to \$1,000,000.00, slightly over

\$1,000,000.00. We started out to raise a few hundred thousand dollars by way of donations and we received pledges of \$150,000.00, but collected only \$25,000.00 to date. I

asked Mr. Watson who is the retired sheriff, and he explained that he had been asked to raise money for the hospital and our people raised by Federal and Provincial grants and our portion of it was, I think, in excess of \$400,000.00. The

of course, the Sisters do have to pay the interest charges. THE CHAIRMAN: The capital as it falls due Mr. PROSCOTT: Yes, but the interest

as it falls due from year to year is still paid for by the salaries of the Sisters of St. Martha who just plough it back in for that purpose. Any excess, if there is any,



1 accommodation, it seems in the old hospital we had quite
2 a demand for the preferred accommodation, but with the new
3 building and the ward facilities being so much better the
4 demand has lessened and the price of the preferred accom-
5 modation has been increased by the pressure of trustees so
6 the preferred accommodation is not so much in demand as
7 we thought it might have been. This results in the income
8 from this particular source not being really great, it
9 helps, but I think presently it is being put back into
10 furnishings and facilities that are still required to bring
11 the plant to what the sisters feel it should be, up to
12 the standard it should be.

13 In our Brief we have commented on things
14 that have been really modernized and one is the physio-
15 therapy department which has been fully equipped with the
16 most modern equipment that is available and we have in-
17 creased our staff to operate it.

18 We do have problems in collections. We have
19 a considerable number of patients come in without hospita-
20 lization cards and this is a continual source of embarrass-
21 ment.

22 THE CHAIRMAN: Would you explain that a
23 little further because we heard either yesterday or the
24 day before that 98.8% of all the residents of Saskatchewan
25 had hospitalization cards.

26 MR. DIELSCHNEIDER: Then we must have a
27 large percentage of that two percent in Melville, because
28 last year we had to write off \$5,000.00 in uncollected
29 accounts receivable. \$1600.00 of that was courtesy, Board
30 Members and staff members and so on but that leaves a



1 considerable amount of uncollected money on the books,
2 because of these fellows who have no cards. We have taken
3 that up with the City Council and they have tried to get a
4 blank insurance card from the Goernment Insurance so they
5 could pay the premium in advance and if this fellow comes
6 along and they know he will come looking for social aid at
7 the same time he is going to need hospitalization, so they
8 could then enter him and have him covered from the day he
9 needs the services of the hospital. The Government has
10 not gone along with the suggestion, so with this 30-day
11 waiting period we do accumulate a lot of debts through the
12 lack of a hospital card.

13 THE CHAIRMAN: Could you give an estimate
14 of what that \$3,600.00 or \$3,400.00 is to the total, per-
15 centage-wise?

16 MR. DIELSCHNEIDER: The figures are on the
17 last page, we have a copy of the financial setup for 1960.

18 THE CHAIRMAN: I see you have Item 4, "unin-
19 sured residents, \$4348.86"?

20 MR. DIELSCHNEIDER: Yes, that is the exact
21 figure for 1961.

22 THE CHAIRMAN: And your charges for preferred
23 accommodation were \$15,403.00?

24 MR. DIELSCHNEIDER: Yes.

25 THE CHAIRMAN: So 50% of that would be
26 \$7,700.00.

27 MR. DIELSCHNEIDER: We have at the moment
28 \$16,000.00 on accounts receivable and some have been turned
29 over to solicitors for collection and so on.

30 THE CHAIRMAN: Those are for uninsured
residents?



1 considerable amount of uncollected money on the books,
2 because of these fellows who have no cards. We have taken
3
4 blank insurance cards from the Government Insurance so they
5 could pay the premium in advance and if this fellow comes
6 along and they know he will come looking for social aid at
7 the same time he is going to need hospitalization, so they
8 could then enter him and have him covered from the day he
9 needs the services of the hospital. The Government has
10 not gone along with the suggestion, so with this 30-day
11 waiting period we do accumulate a lot of debts through the
12 lack of a hospital card.
13
14 THE CHAIRMAN: Could you give an estimate
15 of what that \$1,500.00 or \$2,500.00 is to the total, per-
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1 MR. DIELSCHNEIDER: Yes.

2 THE CHAIRMAN: Would you be able to give the
3 breakdown of what that would be in individual patients?

4 MR. DIELSCHNEIDER: I cannot today.

5 THE CHAIRMAN: But it will be available?

6 MR. DIELSCHNEIDER: Yes.

7 THE CHAIRMAN: Would you also give us the
8 total number of patients for the same period?

9 MR. DIELSCHNEIDER: They will appear

10 THE CHAIRMAN: Oh, yes, 2,803?

11 MR. DIELSCHNEIDER: Yes.

12 THE CHAIRMAN: Yes, the information is here,
13 "uninsured residents patient days 345."

14 MR. DIELSCHNEIDER: These are the forms
15 prepared and sent to the Government each month and the
16 column which I have quoted for the purposes of the Commis-
17 sion is the accumulation of the twelve months and that is
18 the figure for the year 1961.

19 THE CHAIRMAN: Is there anything further
20 you want to say, Mr. Dielschneider?

21 MR. DIELSCHNEIDER: I just wanted to add
22 that we have made pages 8 and 9 of the Brief just generali-
23 zations, more than concerning services we feel we could put
24 to use, and that is with regard to the old age people, who
25 require some medical treatment, but not the use of the
26 hospital bed, and we feel that if some provision could be
27 made along that line, one of the doctors I discussed this
28 with yesterday, assured me that if they had twelve beds
29 within a week they would be full.

30 THE CHAIRMAN: From the hospital?



THE CHAIRMAN: Would you be able to give the

president or vice president would be an individual patient?

I cannot today.

THE CHAIRMAN: But it will be available?

MR. LIEBOWITZ: Yes.

THE CHAIRMAN: Would you also give us the

total number of patients for the same period?

MR. LIEBOWITZ: They will appear....

THE CHAIRMAN: Oh, yes, 1,800?

THE CHAIRMAN: Yes, the information is here.

"Continued residents patient care 1961."

MR. LIEBOWITZ: There are the forms

prepared and sent to the Government each month and the

column which I have given for the purposes of the Commis-

sion is the information on the twelve months and that is

the figure for the year 1961.

THE CHAIRMAN: Is there anything further

you want to say, Mr. Liebowitz?

MR. LIEBOWITZ: I just wanted to say

that we have beds 2 and 3 of the Hotel Just General

section, more than 100,000 patients we feel we could put

to use, and that is with regard to the old age people, who

require some medical attention, but not the use of the

hospital bed, and we feel that if some provision could be

made along that line, one of the doctors I discussed this

when yesterday, assured me that if they had twelve beds

within a week they would be full.

THE CHAIRMAN: From the hospital?



1 MR. DIELSCHNEIDER: No, from the area.

2 THE CHAIRMAN: But in the matter of hospital
3 utilization, have you any in-patients staying on in hospital
4 who could be properly discharged if they had a proper
5 place to go?

6 MR. DIELSCHNEIDER: Yes. It has been a
7 problem right along.

8 THE CHAIRMAN: Are you in a position to give
9 a figure on that?

10 SISTER JOSEPH LEONARD: Yes. Right now we
11 have about eight.

12 THE CHAIRMAN: Out of what total?

13 SISTER JOSEPH LEONARD: Forty-nine.

14 MR. DIELSCHNEIDER: While we were in the old
15 hospital, prior to 1961, we had only a 50-bed capacity,
16 and the Board of Trustees had to get tough with the admini-
17 stration to say to these people: "You cannot stay". So
18 we developed a reputation for that, but with the new
19 hospital, although we feel the reputation might still
20 cling, we have eight patients staying on.

21 THE CHAIRMAN: What is the administration
22 arrangement to see that patients who should leave the
23 hospital do leave the hospital? That they just don't stay
24 on there longer than they should necessarily stay for hospita-
25 lization purposes?

26 MR. DIELSCHNEIDER: I think in principle if
27 the doctor says the man should stay --

28 THE CHAIRMAN: That is quite true, but is
29 there any checking on that administratively?

30 SISTER JOSEPH LEONARD: Usually, Mr. Chairman,



1 I mention to the doctor, and ordinarily they are very good
2 to try to get these patients out.

3 THE CHAIRMAN: Have you a committee, or is
4 the community too small for that?

5 SISTER JOSEPH LEONARD: We have just five
6 doctors on the staff, and they are all committee, so
7 generally the doctor who is in charge of the patient usual-
8 ly takes steps to try to notify a nursing home or something
9 like that, but when they do ordinarily there is a waiting
10 period of a few months.

11 THE CHAIRMAN: Months?

12 SISTER JOSEPH LEONARD: Yes.

13 COMMISSIONER BALTZAN: Sister Joseph, in
14 connection with that, what reason do doctors usually give
15 for having to detain these patients for so long?

16 SISTER JOSEPH LEONARD: Usually, in the first
17 place when the patient is admitted, it is usually someone
18 with an acute condition, and he is treated for that, and
19 then quite often the patient is perhaps debilitated to a
20 certain extent, not able to look after himself altogether.
21 Possibly, if he has a home, the people are not in a position
22 to take care of his nursing and medical needs.

23 COMMISSIONER BALTZAN: Is the fact that you
24 are in a smaller city really serving a rural community,
25 does that make it more difficult to get the patient out of
26 the hospital?

27 SISTER JOSEPH LEONARD: Possibly.

28 MR. DIELSCHNEIDER: There is no centre for
29 these people to which they can be sent. A lot of them are
30 sent to Wolseley, or some of them.



1 THE CHAIRMAN: You are talking about elderly
2 people now?

3 MR. DIELSCHNEIDER: Yes.

4 THE CHAIRMAN: What about the average age,
5 the young and middle-age, is there any overstay in that
6 age group?

7 MR. DIELSCHNEIDER: No, I don't believe so.
8 I think if he is well enough to go home he generally goes
9 home. There is transportation now to see that he gets
10 home and so on, the roads are good.

11 MR. SUTSKI: On page 2, the average stay
12 is 7.4 days.

13 THE CHAIRMAN: How does that compare with
14 the provincial average?

15 MR. SUTSKI: I think they average around
16 six.

17 THE CHAIRMAN: So you are operating about a
18 day and a half over?

19 MR. SUTSKI: That is right.

20 COMMISSIONER STRACHAN: Is there a tendency
21 for those without cards to stay longer?

22 MR. SUTSKI: I wouldn't say so, no.

23 THE CHAIRMAN: What is your per diem rate?

24 MR. SUTSKI: \$16.00, Mr. Chairman. Our
25 cost for the year to date was \$18.47. We are being paid
26 \$16.00. This of course, is pending the operating statement.
27 Of course, our financial statement has not been sent in as
28 yet. Our books have not been audited. The Government will
29 take another look at those, of course.

30 THE CHAIRMAN: Beyond looking, what is done?



1 THE CHAIRMAN: Now, I don't believe so.
2 I think it is well enough to say that he generally goes
3 home. There is transportation now to see that he goes
4 home and so on. The roads are good.
5 MR. SWANSON: On page 2, the average day
6 is 7.4 days.
7 THE CHAIRMAN: Now does that compare with
8 the provincial system?
9 MR. SWANSON: I think they average around
10 six.
11 THE CHAIRMAN: Do you see operating about a
12 day and a half over?
13 MR. SWANSON: Yes, it is right.
14 THE CHAIRMAN: Is that a very heavy
15 load for the road?
16 MR. SWANSON: I wouldn't say so, no.
17 THE CHAIRMAN: What is your per diem rates
18 for the road?
19 MR. SWANSON: I don't know, Mr. Chairman.
20 THE CHAIRMAN: What is your per diem rates
21 for the road?
22 MR. SWANSON: I wouldn't say so, no.
23 THE CHAIRMAN: What is your per diem rates
24 for the road?
25 MR. SWANSON: I don't know, Mr. Chairman.
26 THE CHAIRMAN: What is your per diem rates
27 for the road?
28 MR. SWANSON: I don't know, Mr. Chairman.
29 THE CHAIRMAN: What is your per diem rates
30 for the road?



1 MR. SUTSKI: Well, being in the position
2 that we -- for example, last year we had no definite, should
3 I say experience, since we have had, the capacity has gone
4 up, so we have had no experience, and they claim they are
5 prepared to set a deficit for our hospital that is above
6 the 3% that they have already formulated.

7 THE CHAIRMAN: Because you have no experience
8 to go on?

9 MR. SUTSKI: That is right.

10 MR. DIELSCHNEIDER: Yes, with the new wings
11 being added.

12 THE CHAIRMAN: Do the Sisters of St. Martha
13 operate other hospitals in Saskatchewan?

14 SISTER JOSEPH LEONARD: Yes, we do.

15 THE CHAIRMAN: How many?

16 SISTER JOSEPH LEONARD: Three.

17 THE CHAIRMAN: Where are they?

18 SISTER JOSEPH LEONARD: At Broadview.

19 THE CHAIRMAN: That is a smaller community
20 again?

21 SISTER JOSEPH LEONARD: Yes, it is.

22 THE CHAIRMAN: What is the population of
23 Broadview?

24 MR. DIELSCHNEIDER: About 200.

25 THE CHAIRMAN: On the main line of the CPR
26 from Winnipeg?

27 MR. DIELSCHNEIDER: Yes, it is a farming
28 community.

29 SISTER JOSEPH LEONARD: And Regina, the
30 Mercy Hospital.



1 THE CHAIRMAN: That is not a general hospital.

2 SISTER JOSEPH LEONARD: No.

3 THE CHAIRMAN: Are your experiences at
4 Broadview similar to Melville, insofar as patients' stay
5 and so forth?

6 SISTER JOSEPH LEONARD: I couldn't speak
7 for Broadview, really.

8 SISTER MARY PETER: Sister is just four
9 months in Saskatdewan.

10 THE CHAIRMAN: Now, Mr. Dielschneider, there
11 is another aspect of Melville that may have a bearing. As
12 I understand it, Melville is the only hospital that has
13 tried in recent years a drive to raise funds.

14 MR. DIELSCHNEIDER: I don't know whether it
15 would be the only one in Saskatchewan that has done it,
16 but I know in 1958, we commenced a drive for funds.

17 THE CHAIRMAN: How was that organized? Just
18 hospital based, or how?

19 MR. DIELSCHNEIDER: We canvassed our entire---

20 THE CHAIRMAN: No, I mean, was it just done
21 by the hospital, or was there any community participation?

22 MR. DIELSCHNEIDER: It was a community pro-
23 gram, all denominations in the community. Every organization
24 participated actively in the work.

25 THE CHAIRMAN: And what about the municipal
26 government?

27 MR. DIELSCHNEIDER: The City Council has
28 helped.

29 THE CHAIRMAN: But did they participate in
30 the drive, in the organization of it?



1 MR. DIELSCHNEIDER: As individuals only, but
2 not as a body.

3 THE CHAIRMAN: And you set out to raise
4 \$200,000.00?

5 MR. DIELSCHNEIDER: Yes.

6 THE CHAIRMAN: Were there any elements in
7 the community that were not behind the drive?

8 MR. DIELSCHNEIDER: Well, there was some
9 opposition, but not as such, not against the intent, pur-
10 pose and so on. It was simply a matter of trying to get
11 the dollar from the individual.

12 THE CHAIRMAN: What was that?

13 MR. DIELSCHNEIDER: Well, they just didn't
14 give.

15 THE CHAIRMAN: Did you run into anything of
16 this kind, that because hospitalization was being paid for
17 that there was resistance to giving because hospitalization
18 was already paying for it in an annual premium?

2 19 MR. DIELSCHNEIDER: Yes, I would say the
20 excuse used more often to the canvasser was: "We are al-
21 ready paying the Government for this hospitalization tax
22 and this tax and that tax". It was just a matter that they
23 didn't want to dig into their own private pockets for that
24 dollar. It seems our people are not generally educated to
25 the ideal of voluntary giving, which we were trying to
26 put across. It just didn't go over, and we worked it
27 actively, we worked hard at it.

28 THE CHAIRMAN: And on a non-denominational
29 basis?

30 MR. DIELSCHNEIDER: On a non-denominational



THE CHAIRMAN: There were any elements in

the community that were not behind the driver

of the situation? Well, there was some

opposition, but not as much, not against the labor, but

more against the union. It was simply a matter of trying to get

the better of the individual.

THE CHAIRMAN: Was it a very

well-organized effort? They just didn't

THE CHAIRMAN: Did you have anything or

that there was resistance to giving because of hospitalization

was already paying for it in an annual premium

THE CHAIRMAN: Yes, I would say the

expense was more often on the expense side. The one si-

dearly using the Government for this hospitalization tax

and this was a very large sum. It was just a matter of not

dollar. To meet our people are not generally expected to

the ideal of voluntary giving, which we were trying to

and success. It was a matter of not, and we worked in

activity, we worked hard at it.

THE CHAIRMAN: Now on a non-union situation

MR. BUCHHEIMER: On a non-union situation



1 basis. There were people from all walks of life and all
2 religions represented on the Board, on the Campaign Committee
3 Everybody was involved in it, but to get down to canvassing,
4 and it is a matter of giving, it just does not go over, and
5 that area covered three municipalities, plus the City of
6 Melville, and all the hamlets and villages within, and
7 plus outside points. We covered any company, for example,
8 that was operating in Melville on a national basis. Swift
9 of Canada, for example, the Royal Bank of Canada, and so
10 on. We made all sorts of contacts there and some of them
11 were very good on giving, but other companies having
12 facilities in Melville didn't even reply to a letter.

13 THE CHAIRMAN: They didn't want to deal with
14 individuals?

15 MR. DIELSCHNEIDER: No.

16 COMMISSIONER BALTZAN: You called attention
17 to a very important point of interest to this Commission:
18 "If X-ray and laboratory investigation as well as physio-
19 therapy treatments were covered under our Saskatchewan
20 Hospital Services Plan this too would release beds", and:
21 "Doctors many times are compelled to admit patients for
22 X-ray diagnostic services". Sister, have you an approximate
23 estimate of the number of dollars for these things? Lump
24 them all together, X-ray, laboratory, physiotherapy.

25 SISTER JOSEPH LEONARD: No, we have not.
26 We could send you the figure.

27 COMMISSIONER BALTZAN: Oh, we would be
28 pleased to have it, thank you. Sister, are these services
29 available in Melville outside of the hospital?

30 SISTER JOSEPH LEONARD: In the hospital.



1 COMMISSIONER BALTZAN: It is just for infor-
2 mation that I am asking all these things. Then why are
3 doctors compelled to admit patients only for these purposes?

4 SISTER JOSEPH LEONARD: They are not really
5 compelled only for these purposes, but often a patient who
6 has never been hospitalized for the entire year has paid
7 her premium, and then mostly just during the year she just
8 has an X-ray taken, and yet she finds that she has to pay
9 for that X-ray.

10 COMMISSIONER BALTZAN: Is it because patients
11 feel that they are covered for this in hospital?

12 SISTER JOSEPH LEONARD: Yes.

13 COMMISSIONER BALTZAN: And for that reason
14 the patient actually compels the doctor, as it were. You
15 don't like the word compel, and I don't either.

16 SISTER JOSEPH LEONARD: No, I don't like it.

17 COMMISSIONER BALTZAN: But under the circum-
18 stances, for these reasons, they are then sent into the
19 hospital for these services?

20 SISTER JOSEPH LEONARD: Yes, then too there
21 is preparation beforehand for the X-ray, which the doctor
22 is often interested in.

23 COMMISSIONER BALTZAN: Will you please send
24 us the figures some time?

25 SISTER JOSEPH LEONARD: We will.

26 THE CHAIRMAN: This will be Exhibit number
27 105, and the supplementary submission 105-A, and thank you
28 very much, Sisters and Mr. Dielschneider, and that
29 further information we will be pleased to have after you
30 gather it together and send it to our office in Ottawa.



1 MR. DIELSCHNEIDER: Yes, sir.

3 ---EXHIBIT NO. 105: Submission of St. Peter's Hospital.

4 ---EXHIBIT NO. 105-A: Supplementary submission of St.
5 Peter's Hospital.

6 THE CHAIRMAN: Now we will hear the Canadian
7 Council on Alcoholism. This will be Exhibit number 106.

8
9 ---EXHIBIT NO. 106: Submission of the Canadian Council
10 on Alcoholism.

11 S U B M I S S I O N O F

12 THE CANADIAN COUNCIL ON ALCOHOLISM

13 APPEARANCES:

14 MR. J.F.A. CALDER

15 MR. BERNARD McKENNA

16
17 MR. CALDER: Sir, I think possibly I should
18 mention before we begin that this delegation represents
19 the Saskatchewan Bureau of Alcoholism. We are members of
20 the Canadian Council on Alcoholism, which I know intends
21 to present a Brief to you possibly towards the end of your
22 itinerary in Ontario.

23 Again, not to belabour the point, but pos-
24 sibly to clarify it, more than two months ago the officers
25 of the Canadian Council on Alcoholism asked the member
26 groups if they would submit their ideas of a Brief, and
27 a joint submission would be made. All of the provincial
28 directors said that this idea in general was acceptable.
29 In Saskatchewan, our Bureau submitted several proposals,
30 and I think possibly because of difficulties in getting the



1 main Brief organized, we have never had any word as to
2 whether our proposals would be included. Today we received
3 the first draft of that Brief. It does not contain so far
4 most of the points that we are making on this Brief. Some
5 of the things that we feel in the Bureau of Alcoholism
6 are important at the Federal level do not appear to have
7 the same importance to some of the other provincial alcohol-
8 olism programs. This may be in part explained by the fact
9 that four of these programs are called foundations. They
10 were stimulated by citizens' movements, and although today
11 they are the official provincial programs on alcoholism,
12 most of their budget running in some cases --- more than
13 90% from Provincial Government funds. In Saskatchewan,
14 the Bureau on Alcoholism started in 1953, as a branch of
15 the Department of Health and Welfare. It is a Provincial
16 Government Agency, and operates entirely on Provincial
17 funds. I am the Director and a civil servant, so that the
18 orientation with Government is different than exists in
19 some of the other provinces, where there is considerably
20 more participation by leading citizens as Board Members,
21 considerably more of the pressure group element, in order
22 to get these programs stimulated and underway. I just make
23 that general remark, and I think this is possibly why we
24 are more interested in the development of an alcoholism
25 division in Ottawa within the Ottawa government structure,
26 preferably within the Department of National Health and
27 Welfare. All of us are at present interested in the
28 formation of the Canada Council on Alcoholism, or the
29 Canadian Alcoholism Foundation; I believe this is going to
30 be the name of it. Mr. Monteith was host in June last year



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whether our proposals would be included. Today we received
the first draft of that brief. It does not contain as far
most of the points that we are making on this brief. Some
of the things that we feel in the Bureau of Alcoholism
are important at the Federal level do not appear to have
the same importance to some of the other provincial alcohol-
ism programs. This may be in part explained by the fact
that four of these programs are called "foundations". They
were established by citizens' movements, and although today
they are the official provincial programs on alcoholism,
most of their budget funding in some cases --- more than
60% from Provincial Government funds. In Saskatchewan,
the Bureau of Alcoholism started in 1953, as a result of
the Department of Health and Welfare. It is a provincial
Government agency, and operates entirely on Provincial
funds. I am the Director and a civil servant, so that the
cooperation with Government is different than exists in
some of the other provinces, where there is considerably
more participation by leading citizens as Board Members,
considerably more of the private group element, in order
to get these programs established and underway. I shall make
that general remark and I think this is possibly why we
are more interested in the development of an alcoholism
division in Ottawa within the Ottawa Government structure.
Previously within the Department of National Health and
Welfare. All of us are at present interested in the
formation of the Canada Council on Alcoholism, or the
Canadian Alcoholism Foundation; I believe this is going to
be the name of it. Mr. Wenzel was host in June last year



1 to a very large deputation which consisted of the
2 representatives of the Provincial Alcoholism programs and
3 representatives of many national organizations and industries
4 in his office in Ottawa where the first plans were made for
5 a Canadian Alcoholism Foundation, and this foundation is
6 going to seek funds from national industries and also from
7 the Federal Government to maintain a central secretariat
8 to distribute funds for research purposes across the country.
9 Throughout the planning for this our Bureau has said that
10 this is a worthwhile venture and we support it. And on
11 the left, we feel that at this stage of development the
12 groundwork has been done and that it is now time for
13 Ottawa to take leadership in attacking what we consider to
14 be one of the country's major health and social problems.
15 In magnitude it seems to rank with heart disease, cancer
16 and mental illness. It has been denied at all levels and
17 has remained hidden like certain other diseases in the
18 past against which there was considerable stigma. It is
19 now coming out in the open, and people are preparing to
20 attack it. We feel apart from what is done at the
21 Provincial level or by national citizen groups that Ottawa
22 should at least create a division or sub-division which
23 should examine the various kinds of submissions that are
24 made to our Government. It should set up its own competent
25 staff to give direction and to aid and stimulate the
26 development of what resources become proven to be needed
27 to attack this problem properly. So, we have placed a
28 great deal of emphasis at this point in our Brief, and how
29 far the Canadian Council -- which is a very informal group
30 of provincial directors -- how far they will go in this



1 direction I don't know, but we waited until the last
2 minute before organizing and presenting this Brief to see
3 whether our ideas would be carried forward in that of the
4 Canadian Council.

5 Pardon me for talking about this matter in
6 the beginning at such length.

7 THE CHAIRMAN: It is very good because we
8 will naturally be receiving the national brief, and when
9 we do we will have your Brief as well to go along with the
10 submissions that are then made and to add to any deficiencies
11 which you think should have been dealt with, and tie the
12 two together and so get the whole picture as you want it
13 put forward. Will that meet with your approval? Is that
14 the way you think it should be handled?

15 MR. CALDER: We were very much hoping it
16 would, sir.

17 THE CHAIRMAN: That would appear to be better
18 than for us to take this piecemeal now and the other later.
19 I suppose you won't be present, or anybody else from
20 Saskatchewan, when the other brief is given?

21 MR. CALDER: I don't imagine so, sir. I
22 think there will probably just be a small group of people;
23 possibly Mr. Archibald, the Secretary -- Mr. Strachan, the
24 director of the Alberta Alcoholism Foundation, which is
25 again a citizens' group. He is our Secretary and Mr.
26 Archibald is our Chairman.

27 THE CHAIRMAN: On that occasion, when the
28 Canadian brief comes in, the group then will be questioned
29 not only their brief, but on your submissions and ideas as
30 well.



1 MR. CALDER: Yes, sir., When the rather
2 large meeting was held in Ottawa in Mr. Monteith's office
3 in June I had interviews with Dr. Morgan Martin, the
4 Director of the Mental Health Division, and with Dr.
5 Cameron, the Deputy Minister of National Health and Welfare,
6 and I expressed my views about the necessity for Ottawa
7 to move into this field immediately. I got a very courteous
8 hearing from both these officials and they questioned me
9 at length. Dr. Cameron asked me to submit my ideas in
10 writing to him, which I have done. In the outline there
11 are specific recommendations about the staffing and that
12 sort of thing. I have had no further word, but I have no
13 doubt these ideas will be weighed along with others, and
14 I may mention there is on record in the Deputy Minister's
15 office in Ottawa some of the general outline on how such
16 a division could be set up.

17 THE CHAIRMAN: That will be made available
18 to us, because the liason between the Commission and the
19 Department is very close. I take it that you will be
20 advising your national office that you filed this Brief
21 with us here today?

22 MR. CALDER: Yes, they already have been
23 mailed copies of this.

24 THE CHAIRMAN: And you will have a copy of
25 the submission they will be making?

26 MR. CALDER: Yes, sir; we have the first
27 draft today and we are to send in our suggestions and cor-
28 rections and we will get any further drafts as they come
29 along.

30 THE CHAIRMAN: So you will have an opportunity



1 MR. GARDNER: Yes, sir. When the rather
2 large meeting was held in Ottawa in Mr. Montclair's office
3 to which I had been invited with Dr. Morgan Hamilton, the
4 Director of the Mental Health Division, and with Dr.
5 Bennett, the Deputy Minister of National Health and Welfare,
6 and I expressed my views about the necessity for Canada
7 to have such this kind of officials. I got a very warm
8 reaction from both these officials and they questioned me
9 at length. Mr. Bennett asked me to submit my ideas in
10 writing to him, which I have done. In the outline there
11 are specific recommendations about the staffing and what
12 kind of training I have had to furnish work, but I have no
13 doubt these things will be weighed along with others, and
14 I am confident there is an answer to the Deputy Minister's
15 question in the form of the general outline of how such
16 a system could be set up.
17 MR. GARDNER: That will be made available
18 to all members of the committee and the
19 Department is very close. I am sure that you will be
20 able to give your personal office that you filed the letter
21 with a copy today.
22 MR. GARDNER: Yes, they already have been
23 mailed copies of this.
24 MR. GARDNER: And you will have a copy of
25 the committee's report to be working?
26 MR. GARDNER: Yes, sir; we have the report
27 draft today and we are to send in our suggestions and our
28 reactions and we will get any further drafts as they come
29 along.



1 to see your views are contained -- or, at least, put for-
2 ward to be contained.

3 MR. CALDER: We will see what is finally
4 done, yes.

5 THE CHAIRMAN: And if they are not contained,
6 then this Brief you have today will be before us at that
7 time.

8 MR. CALDER: Yes, sir, and I tried to predict
9 what I thought were least likely to be presented in the
10 national brief. In Saskatchewan we have made only one
11 recommendation. Our recommendations were what we thought
12 the National Government should do at the national level.
13 With regard to our own Province we state that the fullest
14 support should be given to Dr. Hoffer and his group. This
15 was all new.---

16 THE CHAIRMAN: Yes, it is most interesting.

17 MR. CALDER: We had recoveries from the very
18 worst type of cases using some of the new drugs, and Dr.
19 Hoffer and his group have developed L.S.D.-25, mescaline,
20 cylecibin and peyote. We were terrifically stimulated by
21 this. The whole project is in danger of dying away as far
22 as Alcohols are concerned because they are working with
23 very limited funds and staff. In some aspects of their
24 work they provided world leadership and have done a terrific
25 job. We have the happiest relationship with them and I
26 can't say too strongly that because of the dramatic nature
27 of this work and of the rather challenging aspect of it,
28 with orthodox ideas, it is difficult to get acceptance.
29 It seems to me, when in Canada a small group of devoted
30 scientists have done the work these people have done, and



We will see what is finally

THE CHAIRMAN: And if they are not convinced
I don't think you have today will be before us at least

at least you, and I think to predict
what I thought were less likely to be presented in the

the central committee should be at the national level
with regard to our own. I think we agree that the subject

should be given to Mr. Holler and Mr. Group. This
is a very interesting

THE CHAIRMAN: Yes, it is most interesting
I think we had recognized from the very

even when some of the other things and the
the other things and the other things

we were not finally satisfied by
it is in danger of dying away as far

We have the closest relationship with them and I
can't say too strongly that because of the dramatic nature

of this work and of the rather challenging aspect of it,
with orthodox ideas, it is difficult to get acceptance.

It seems to me, when in Canada a small group of devoted
enthusiasts have done the work these people have done, and



1 opened up such wonderful horizons for the treatment
2 of not only alcoholism, but mental illness, which now seems
3 to be becoming an increasingly important field, that I
4 think every sort of backing should be given them. We have
5 our direct interest, of course, in the treatment of alcoholics,
6 but the work they have done with psychopaths and
7 young jail offenders, and psychotics and people with
8 schizophrenia -- all sorts of amazing leads have been
9 opened up. They need help. Some work is going on in
10 California and New York, but in Saskatchewan Dr. Hoffer and
11 his group have really given of their patience and faith
12 and persistence and they seem to me to have gone further
13 than anyone else.

14 THE CHAIRMAN: Thank you very much. You
15 may be assured this matter will receive the consideration
16 of the Commission.

17 MR. CALDER: Thank you, sir.

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S U B M I S S I O N O F

THE REGINA GREY NUNS' HOSPITAL

APPEARANCES:

MR. J. DUPONT

MRS. C. SHERIFF

MR. G. HIEBERT

MR. M. SAWCYN

MR. W. L. VANDERGARD

---EXHIBIT NO. 107: Brief of the Regina Grey Nuns' Hospital.

MR. DUPONT: Mr. Chairman, we have remained within the frame of the suggestions you have made regarding admitting and discharge and turnover of patients in the hospital. In our first paragraph we indicate we have 462 beds, a decrease of eight in the last two years, and gradually because of the demand for extra services we had to shorten or curtail some of our beds.

A review of the last seven years' annual reports provides us with the following information:

Discharges	% of occupancy (excl. bassinets)	Newborns	Av. day's stay
1955 - 11,691	87.8	60.66	14.03 days
1956 - 12,172	87.04	59.7	13.3 "
1957 - 12,513	89.4	62.8	13.5 "
1958 - 12,942	88.6	64.	12.8 "
1959 - 13,125	88.1	64.2	12.6 "
1960 - 13,574	87.9	63.9	11.9 "
1961 - 13,579	88.0	64.	11.9 "

The generally accepted standard of utilization is 80%. Our average indicates that we now have a peak load the year round



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THE

APPROPRIATE

MR. J. W. WILSON

MR. J. W. WILSON

MR. J. W. WILSON

MR. J. W. WILSON

EXHIBIT NO. 107
 [Illegible text]

MR. WILSON: [Illegible text]

Within the frame of the [illegible] and you have made regarding
 [illegible] and [illegible] and [illegible] in the
 [illegible]. In our first paragraph we [illegible] we have [illegible]
 [illegible] a [illegible] of [illegible] in the [illegible] [illegible] [illegible]
 [illegible] because of the demand for [illegible] [illegible] we had
 to [illegible] of [illegible] some of our [illegible]
 A review of the last seven years' annual

reports provides us with the following information:

Year	Revenue	Expenses	Profit
1925 - 1926	87.8	60.0	27.8
" 1926 - 1927	87.0	59.0	28.0
" 1927 - 1928	87.4	62.8	24.6
" 1928 - 1929	88.6	64.0	24.6
" 1929 - 1930	87.9	63.9	24.0
" 1930 - 1931	88.0	64.0	24.0

The generally [illegible] and [illegible] on utilization is [illegible] our
 average [illegible] that we now have a peak load the year



In the next paragraph we find our urgent cases demand a longer period than they should for admission. Generally three or four days is the recommended time, and we extend it to fifteen days or more -- even a month in some cases.

On January 11th of this year we carried out a survey, and the occupancy rate on this day was 91.1 %, excluding bassinets. The age distribution indicates the highest percentage was in the 60 years and over category: 168 out of 458. Then, in sub-section (c) we indicate that 128 were emergency patients, which seems to be a high percentage.

The present condition of hospitalized patients was categorized as follows:

<u>Acute</u>	<u>Convalescent</u>	<u>Chronic</u>
112 = 29.3%	165 = 43.2%	105 = 27.5%

These figures represent 382 patients

Maternity 40

Nursery 36

458 patients

Of the 105 chronic patients, 16 or 4.2% were awaiting outside accommodation.

THE CHAIRMAN: This is on January the 11th?

MR. DUPONT: January the 11th, sir. We left off the maternity and nursery patients.

THE CHAIRMAN: Just before you leave that, where you have 105, that is 27½% chronic?

MR. DUPONT: Yes, chronic. We mean they have an acute phase of a chronic condition. It is not a chronic condition per se.

agreed we find our meeting

Generally three or four days is the recommended time, and
no longer than fifteen days or more -- even a week in

some cases.

a survey, and the emergency rate on this day was 21.1%.
existing before war. The age distribution indicates the
highest percentage was in the 60 years and over category.
1968 and in 1967, 1966, in all sections. It is indicated that
1968 were emergency patients, which seems to be a high

percentage.

The present condition of hospitalized patients was

referred as follows

Emergency

Admit

105 = 43.3%

110 = 44.3%

These figures represent 382 patients

Emergency 40

Emergency 30

168 patients

Of the 168 patients, 10 of 168 were emergency patients

MR. CHAIRMAN: This is on January 15, 1968.

MR. CHAIRMAN: January 15, 1968, and we will

of the emergency and emergency patients

MR. CHAIRMAN: Just before you leave that.

Now you have 105, that is 43.3% emergency

MR. CHAIRMAN: Yes, correct. We mean 105

Now an acute phase of a chronic condition. It is not a

chronic condition per se



1 Effective and Efficient use of hospital facilities

2 Outpatient services:

3 In 1961, outpatients treated in the

4 Dressing Room are, as follows: Emergency 6,072

5 Elective 1,781

6 Total 7,853

7 A rapid review of our annual statistics provides us with
8 totals of minor conditions, which probably could be treated
9 on an outpatient basis:

10 Tonsillectomies: 857 x 2 days = 1714 days

11 Dental extrac-
12 tions : 150 x 2.7 days = 407 days

13 Other minor surgery)
14 such as biopsies, foreign) one a day
15 bodies, skin conditions,) or 365 x 2 = 730 "
16 cystoscopies and plaster)
17 casts) Total 2851 days

18
$$\frac{2851 \times 100}{265 \times 88.1} = 8.86 \text{ beds}$$

19 Such a service would require at least two
20 minor surgery operating rooms, which we now have. Considera-
21 tion would have to be given to increased waiting room and
22 recovery room facilities.

23 In five (b), Mr. Chairman, this has been
24 very difficult to assess, because we do feel like ----

25 THE CHAIRMAN: In paragraph five (a), 2851
26 days: Your daily rate is what?

27 MR. SAWCYN: \$18.38, sir.

28 MR. DUPONT: In paragraph five (b), the out-
29 patient diagnostic services, we have indicated that this
30 is a difficult matter to restrict only to hospitals. A
good number of our clinics here have developed these ser-
vices and they are providing a good service. As a matter of



1 fact, we feel that most of our patients who come in, that
2 a good number of them don't come in for diagnostic services
3 per se. Those who have diagnostic services come in for
4 other conditions. We do say those who do come in may have
5 had some diagnostic services prior to entering hospital.
6 On this basis we also recognize that with certain labora-
7 tory and radiological services available downtown it does
8 help the physician to give good service. The patient
9 doesn't have to go back; or the doctor doesn't have to
10 wait for a number of reports.

11 In paragraph six, the average days' stay is
12 11.9, a reduction of 2.1 days in the last several years.

13 THE CHAIRMAN: How does that compare to the
14 Provincial average?

15 MR. DUPONT: I would say the average is
16 around ten days.

17 THE CHAIRMAN: What is a fair average for
18 the five large hospitals?

19 MR. DUPONT: I know the General Hospital is
20 11.7 -- virtually the same.

21 We also indicate that a high percentage of
22 our operations are major operations -- forty percent. If
23 I may just go back earlier in the paragraph, we indicate
24 the days of surgery are 4.4, and possibly if we could de-
25 crease this we would save on bed days.

26 THE CHAIRMAN: A patient is in hospital an
27 average of four and a half days before undergoing surgery?

28 MR. DUPONT: On an average.

29 THE CHAIRMAN: And you think that might be
30 shortened?



1 I think we feel that most of our diagnostic services
2 a good number of them don't come in for diagnostic services
3 but are. There who have diagnostic services come in for
4 diagnostic services. The diagnostic services are not
5 diagnostic services. The diagnostic services are not
6 diagnostic services. The diagnostic services are not
7 very and radiological services available. It does
8 help the patients to give good service. The patients
9 couldn't have to go back, or the doctor doesn't have to
10 wait for a number of reports.

11
12
13
14
15 THE CHAIRMAN:

16 The physical evidence?
17
18 MR. TAYLOR: I would say the average is

19
20 THE CHAIRMAN: What is a fair average for
21 the time in hospital?

22
23
24
25

26 It also indicates that a high percentage of
27 the patients are under observation -- forty percent. It
28 has been the case in the past. We indicate
29 that the patients are under observation. We indicate
30 that the patients are under observation. We indicate
31 that the patients are under observation. We indicate

32 THE CHAIRMAN: A patient is in hospital and
33 average of four and a half days before undergoing surgery
34
35 MR. TAYLOR: On an average.



1 MR. DUPONT: I think as we mentioned that
2 certain outpatient facilities where the patient could be
3 prepared and investigation done on a patient we would not
4 have to wait to do this investigation.

5 With long stay patients, on item 7 we did
6 a survey covering a two-month period and we found our
7 patients discharged within thirty days. The number of
8 cancer patients are shown in brackets.

9 Female Rural - 30 (16) Female Urban - 14 (4)

10 Male Rural - 19 (8) Male Urban - 19 (6)

11 Total - 49 Total - 33

12 Average days' stay = 75 days Average days' stay = 94.5
13 days

14 Disposition of these cases

15 17 expired

16 59 Home

17 5 Nursing Homes

18 1 Transferred to country hospital

19 82

20 The five patients transferred to nursing
21 homes totalled 836 hospital days or an average of 167 days
22 each. Availability of immediate nursing home care would
23 have considerably shortened these hospital stays and may
24 have liberated the equivalent of two beds over a year.
25 Many of the 17 who expired possibly could have also been
26 cared for a certain period in geriatric centres.

27 THE CHAIRMAN: You only show one out of 82
28 going to a country hospital.

29 MR. DUPONT: Or they may be transferred home,
30 that is another possibility. We feel that rural patients,



1 that the rural people would accept patients home more than
2 city people.

3 THE CHAIRMAN: Do you mean to say the city
4 people stay longer out of choice?

5 MR. DUPONT: We find it more difficult to
6 discharge them.

7 THE CHAIRMAN: And the discharging, of course,
8 is done by the physician, do you mean to say he applies a
9 different rule to a country patient and an urban patient?

10 MR. DUPONT: We try to work with the families,
11 with the agencies, to discharge them as quickly as possible,
12 but we cannot turn a patient out who has a long-term illness
13 and requires some medical care and partial nursing care.

14 COMMISSIONER FIRESTONE: What are the
15 conditions that do not prompt these people to go home? Is
16 it home accommodation, lack of care at home?

17 MR. DUPONT: I think another factor, they
18 are treated by certain doctors in the urban area and it is
19 difficult at times because of the type of treatment to send
20 them home.

21 THE CHAIRMAN: Urban is in the city like
22 Regina.

23 MR. DUPONT: Well, those are the figures we
24 came up with.

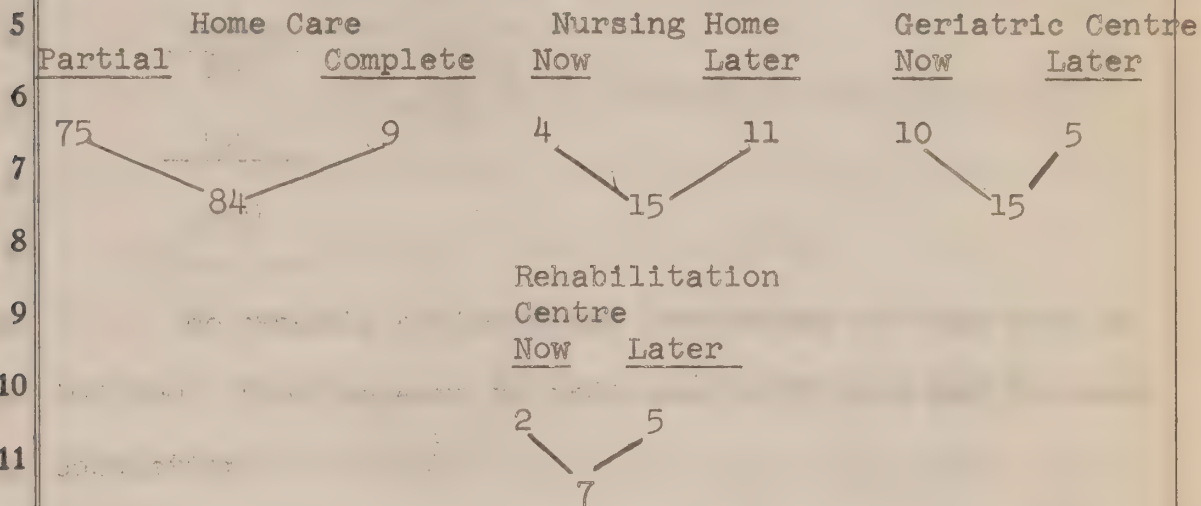
25 Long stay patients - in Hospital

26 We reviewed our hospital patients with over
27 45 days' stay. There were a total of 27 divided fairly
28 equally as to sex. 14 were rural, and 13 urban. 10 were
29 cancer patients. 18 were over 60 years of age.

30 Patients in hospital 30 days or over



1 totalled 72. This represents 18.5% of our hospital census,
2 if we exclude maternity patients and newborn infants.
3 Our survey gave us this pertinent information on care
4 required following discharge:



13 Out of 382 patients in hospital (excluding maternity
14 and nursery), there were 84 who would require home care on
15 a partial (75) or complete basis (9). The latter nine could
16 possibly be candidates for nursing home or geriatric centre.
17 Fifteen would require nursing home care, of which four
18 were presently awaiting admission. Fifteen are candidates
19 for the geriatric centre, of which 10 are awaiting admission.
20 Seven would benefit from rehabilitation care, of which 2
21 are awaiting admission.

22 Immediate transfer of the patients on the waiting
23 list would liberate 16 beds for acute illnesses. Of the
24 30 others slated for nursing or rehabilitation care, most
25 could be transferred if facilities were readily available.
26 This gives us a potential of 46 beds freed by chronic
27 patients. We have mentioned earlier that outpatient ser-
28 vices would save 9 active beds.

29 On a conservative note, we estimate that outpatient
30 services and adequate facilities for chronic care would
relieve our hospital of 55 beds or $\frac{55 \times 100}{462} = 11.1\%$ of our
bed total.



1 Active Beds in Regina

2		Active	Bassinets	Mental Wing
3	General Hospital	706	67	34
4	Grey Nuns' Hospital	462	60	
5		1168	127	34 =
6	<u>Total</u>	<u>807</u>		
7				
8	<u>522</u>			
9	<u>1329</u>			

10 We roughly estimate the population of this city at
11 100,000. This appears to indicate 11.68 beds per thousand
12 population.

13 Previous surveys have shown that approximately 40%
14 of patients admitted to Regina hospitals are from rural
15 areas.

16 Our calculations, therefore, show that
17 $6 \times 11.68 = 7.008$ beds are available for the residents of
18 ¹⁰ this city.

19 Because the majority of the rural referred patients
20 are considered as having major illnesses, we assume that,
21 on the average, the hospital stay is longer. This factor
22 may be so great as to further influence the availability of
23 beds for our local citizens to the point of equalling 1 bed
24 per thousand. If so, we arrive at a figure of 6 beds per
25 thousand population.

26 We have not endeavoured to assess the days saved by
27 the patients requiring home care, because of our present
28 unfamiliarity with the operation of such a plan.

29 In summary, we feel that we have adequate hospital
30 beds. We need a home care programme, a chronic hospital or
preferably chronic wings on our present general hospitals
and developed outpatient services.



1 THE CHAIRMAN: Thank you very much, Mr.
2 Dupont. I must say that your response to our request for
3 this type of information has been most adequately met and
4 I know that this must put you and your staff to a very
5 considerable amount of work.

6 Now, perhaps in justification for having
7 made the request, we are faced with this situation that
8 the cost of operation of general hospitals in Canada in
9 the past year was \$675,000,000.00 and that is why this
10 question of the length of stay is of such importance.
11 If by any reasonable approach to the problem those who are
12 eligible to be discharged on a certain date are discharged
13 and do not remain over an extra day or an extra two days
14 for one reason or another, there may well be a saving of
15 even one day, roughly 10% and translated into that could
16 be \$100,000,000.00. That is why we are interesting our-
17 selves in this question of hospital stay and possibly
18 over-utilization of the acute hospital beds. And now,
19 administratively, how is the question of discharges handled
20 in your hospital?

21 MR. DUPONT: We review every patient with
22 at least thirty days stay; the Government also requires we
23 complete a form in thirty days. At one time the medical
24 staff reviewed on a twenty-day stay and found they were
25 doing a lot of reviewing without any great necessity, so
26 we changed it to thirty days.

27 THE CHAIRMAN: To harmonize with the
28 Government's requirements?

29 MR. DUPONT: We reviewed those who are dis-
30 charged and those in the hospital over thirty days. Our



1 Department does a review and reports to the Committee.

2 THE CHAIRMAN: Do you think you could expect
3 any improvement without these auxiliary beds or institutions
4 that you have mentioned?

5 MR. DUPONT: I do not feel at the present
6 time we can expect too much improvement.

7 THE CHAIRMAN: If you had the other accommo-
8 dation?

9 MR. DUPONT: If we had the other accommoda-
10 tion, yes. You realize our waiting list is very extensive
11 at the present time and that is why we have to have a good
12 turnover on patients.

13 COMMISSIONER VAN WART: May I just make one
14 observation? The thing that impresses me on this submission
15 is that the average age of the delegation is very much
16 younger than the delegations that have been appearing
17 before us. I think this augurs well for hospitals in Regina.

18 COMMISSIONER BALTZAN: An excellent analysis
19 and most instructive.

20 THE CHAIRMAN: Again I want to say that we
21 have to express our grateful thanks to you for all the
22 trouble you went to in making the analysis in the first
23 place and developing it so clearly and concisely. This
24 will be of great value to us and we will be able to produce
25 it as a model in dealing with other hospitals and in pursu-
26 ing our inquiries. We are very grateful to you.

27 MR. DUPONT: We thank you. It has been a
28 pleasure and we quite realize it will be beneficial to us
29 also.

30

that you have mentioned?

MR. TUPONT: I do not feel at the present

time we can expect too much improvement.

THE CHAIRMAN: If you had the other section

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THE CHAIRMAN: We will now adjourn until
tomorrow morning a nine o'clock.

---Adjournment.

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

REGINA

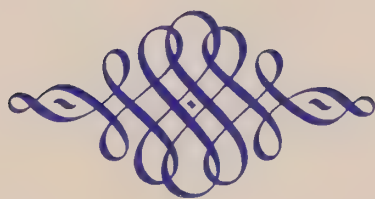
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VOLUME NUMBER :

21

DATE:

JANUARY 26 1962



OFFICIAL REPORTERS

ANGUS, STONEHOUSE & CO. LTD.
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STATE OF NEW YORK
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IN SENATE
 JANUARY 10, 1900.

REPORT OF THE
 COMMISSIONER OF THE LAND OFFICE

IN RESPONSE TO A RESOLUTION
 PASSED BY THE SENATE
 APRIL 10, 1899.

ALBANY:
 J. B. LEECH, PRINTERS.

1900. NOT RECORDED

NEW YORK:
 J. B. LEECH, PRINTERS.

1900. NOT RECORDED

CHAPTER 100

1900. NOT RECORDED

1900. NOT RECORDED

1900. NOT RECORDED

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VOLUME 21

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held in Regina, Saskatchewan,
26th day of January, 1962.

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL -- Chairman

MISS ALICE GIRARD, R.N.

DR. DAVID M. BALTZAN

PROF. O.J. FIRESTONE

MR. M. WALLACE McCUTCHEON, Q.C.

DR.C.L. STRACHAN

DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. N. LAFRANCE



UNITED STATES DEPARTMENT OF JUSTICE

INVESTIGATION OF THE ACTS OF VIOLENCE

REPORT OF THE COMMISSIONER OF THE BUREAU OF INVESTIGATION

UNITED STATES DEPARTMENT OF JUSTICE

REPORT OF THE COMMISSIONER OF THE BUREAU OF INVESTIGATION

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UNITED STATES DEPARTMENT OF JUSTICE



Regina, Saskatchewan,
Friday, 26th January,
1962.

--- On commencing at 9 a.m.

SUBMISSION OF THE DEPARTMENT OF SOCIAL WELFARE
AND REHABILITATION, PROVINCE OF SASKATCHEWAN

Appearances: Hon. A.N. Nicholson
Mr. R. Talbot
Mr. A. Sihvon
Mr. D. Chalmers
Dr. B. Kobrynski
Mr. E.D. Donaldson
Mr. W. Totton

THE CHAIRMAN: We will now come to order, and the Honourable Mr. Nicholson and gentlemen from his Department are here at our invitation, and we are grateful to you, Mr. Nicholson, for being here, and for your good nature in being shifted from the other morning until today. It has assisted us in the organization and continuation of our program by making some changes, and we are grateful to you for standing by at the time and coming this morning.

Now I am going to ask Dr. Firestone to begin developing some of the ideas we have in mind relative to the information which we would like, and which we think you would be able to give us help on.

COMMISSIONER FIRESTONE: Mr. Chairman, I would like to say first of all that I am very happy to renew my acquaintance with the Minister, who I have known for a number of years in Ottawa, and like yourself I am very much indebted to the Minister for taking time out of a very busy schedule. I know how important it is to do your own work, but you are very kind to help us out with



Friday, 28th January,
Ottawa, (Wednesday)

(On commencing at 9 a.m.)

SUBMISSION BY THE DEPARTMENT OF SOCIAL AFFAIRS
AND RELATIONS, PROVINCE OF SASKATCHEWAN

- Mr. R. L. Lefebvre
- Mr. J. L. Lefebvre
- Mr. D. L. Lefebvre
- Mr. S. L. Lefebvre
- Mr. A. L. Lefebvre
- Mr. W. L. Lefebvre

THE CHAIRMAN: We will now come to order,
and the Honorable Mr. Nicholson and gentlemen from his
Department are here at our invitation, and we are pleased
to have you, Mr. Nicholson, for being here, and for your
good nature in being invited from the other side, until
today. It has assisted us in the organization and contin-
uation of our program by making some changes, and we are
grateful to you for standing by at the time and coming
this morning.

Now I am going to ask Mr. Lefebvre to
begin developing some of the ideas we have in mind rela-
tive to the institution which we would like, and which we
think you would be able to give us help on.

COMMISSIONER LEBEYECQ: Mr. Chairman,
I would like to say first of all that I am very pleased to
renew my acquaintance with the Minister, who I have known
for a number of years in Ottawa, and like yourself I am
very much indebted to the Minister for taking time out of
a very busy schedule. I know how important it is to do
your own work, but you are very kind to help us out with



1
2
3 some of the questions that interest us.

4 Some of the questions concern primarily
5 the conditions in Saskatchewan, but being a Royal
6 Commission concerned with the health situation in Canada
7 as a whole, we hope to learn from some of your experiences
8 certain lessons that we might apply in a broader concept,
9 so we are particularly grateful for your appearance.

10 It has been represented to us that some
11 of the hospital facilities which are available in our
12 province as well as in others, are perhaps not used as
13 efficiently as could be the case if there were more ade-
14 quate facilities to take care more effectively of the
15 aged, whether homes for the aged, or institutions. It
16 would help us to learn a little bit more about what faci-
17 lities are available in Saskatchewan to take care of the
18 aged, housing for senior citizens, and institutions for
19 aged people who cannot afford to look after themselves.

20 HON. MR. NICHOLSON: I am sure I speak
21 for all the citizens of this province when I say thank
22 you to you for coming to Saskatchewan in January and
23 being so very patient for a very busy week. I am sure
24 that the briefs presented to you will indicate that you
25 are dealing with a subject that is very interesting to
26 the people of our province. I am sure that the views
27 you receive from a great many organizations will be a
28 good deal of help to you in preparing your report.

29 Just in case you haven't seen the Report
30 of the National Health Survey, Dr. Firestone will be
familiar with this document, and I mention it to indicate
that we have been interested in health here for a long



some of the questions that interest us.

Some of the questions concern primarily

the conditions in Saskatchewan, but being a Royal Commission concerned with the health situation in Canada as a whole, we hope to learn from some of your experience certain lessons that we might apply in a broader context, so we are particularly grateful for your appearance.

It has been requested to us that some

of the hospital facilities which are available in our province as well as in others, are perhaps not used as efficiently as could be the case if there were more adequate facilities to take care more effectively of the aged, whether homes for the aged, or institutions, or would help us to learn a little bit more about what facilities are available in Saskatchewan to take care of the aged, housing for senior citizens, and institutions for aged people who cannot afford to look after themselves.

Now, Mr. Nicholson: I am sure I speak

for all the citizens of this province when I say thank you to you for coming to Saskatchewan in January and being so very patient for a very busy week. I am sure that the private members to you will indicate that you are dealing with a subject that is very interesting to the people of our province. I am sure that the views you receive from a great many organizations will be a good deal of help to you in preparing your report.

Just in case you haven't seen the report

of the National Health Survey, Mr. Nicholson will be

that we have been interested in health here for a long



1
2
3 time. It is not easy for those from outside the
4 province at this time of the year to understand why
5 people come to Saskatchewan to spend a lifetime, but
6 people like the Chief Justice will recall that one of
7 one's best experiences is living in a small community,
8 where we have a lot of problems.

9 This was done by Order in Council in 1942,
10 which covered the whole Canadian scene, and I hope as a
11 result of your work you will be able to put together
12 some more up-to-date information, but in answer to the
13 question that Dr. Firestone asks regarding the care for
14 the chronically ill, back in 1943 this was a very critical
15 problem in all parts of Canada, and as a result of the
16 excellent work that Dr. Baltzan and his colleagues across
17 Canada are doing, people are going to be living a lot
18 longer from now on, and we are going to have to assume
19 that a great many people will live to 100, and it is not
20 only important that we live longer, but that we remain
21 well longer, and to deal with the problems in this area
22 I might say since 1953 Saskatchewan has had an arrangement
23 with the Government, whereby we share in the housing
24 arrangements for the senior citizens. Up till recently,
25 Saskatchewan was the only province who took advantage of
26 the arrangement where the Government loaned 72%, the
27 municipalities involved raised 8%, the Provincial Govern-
28 ment gave an outright grant of 20%, and in more than 40
29 communities within the province we have been sharing by
30 the three levels of government in this activity, and we
are finding that in the hospitals where they have good
food three times a day, bachelors particularly who have



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time. It is not easy for those from outside the
province at this time of the year to understand why
people come to Saskatchewan to spend a lifetime, but
people like the Chief Justice will recall that one of
one's best experiences is living in a small community,
where we have a lot of contact.
This was done by Dr. [Name] in [Location] in [Year],
which covered the whole [Location] area, and I was as a
result of your work you will be able to get together
some more up-to-date information, but in answer to the
question that Dr. [Name] asks regarding the time for
the chronology of it, but in 1945 there was a very different
problem in all parts of Canada, and as a result of the
excellent work that Dr. [Name] and his colleagues across
Canada are doing, people are going to be living a lot
longer from now on, and we are going to have to realize
that a great many people will live to 100, and it is not
only important that we live longer, but that we remain
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I might say since 1953 Saskatchewan has had an arrangement
with the Government, whereby we share in the housing
arrangements for the senior citizens. Up till recently,
Saskatchewan was the only province who took advantage of
the arrangement where the Government loaned 12%, the
municipalities involved raised 8%, the Provincial Govern-
ment gave an outright grant of 20%, and in some cases
committees within the province we have been assisted by
the three levels of government in this activity, and we
are finding that in the hospitals where they have good
food three times a day, excellent transportation, and



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4 been living alone for 30 or 40 years develop some careless
5 cooking habits, so with three good meals a day they take
6 a new lease on life.

7 His Worship the Mayor of Saskatoon and
8 myself made presentations to a bride and groom. The
9 groom was 86, living in one of the homes.

10 COMMISSIONER FIRESTONE: How old was the
11 bride sir?

12 HON. MR. NICHOLSON: But we are finding
13 that as a result of these improved facilities a great
14 many of our people who have been living alone have better
15 food, and are going to be living longer, but we also have
16 the problem that at some point people need care that is
17 not available. These are hostels, and the arrangements
18 are that our Department must provide arrangements in one
19 of our geriatric centres for those who cannot care for
20 themselves in one of the hostels. We have three centres,
21 Regina, Melfort and Saskatoon, where we share with the
22 Federal Government under the sharing hospital program.

23 In Wolseley, in a fourth centre, we have
24 a geriatric centre which is not shareable, where people
25 do not require such active care.

26 I have some of my officials here who I
27 think might supplement. Dr. Kobrynski works particularly
28 in this field. Mr. Chalmers is the Head of our Housing
29 and Home Branch. Perhaps I might ask Dr. Kobrynski if
30 he would care to supplement what I have said regarding
the availability of care for the group of elderly people
in such general hospitals. Some are in our hostels, who
require more active nursing care, and Mr. Chalmers, our



been living alone for 30 or 40 years develop some careless cooking habits, so with three good meals a day they take a new lease on life.

His wife, the widow of a doctor, and

myself were presentations to a bride and groom. This

room was 80, living in one of the houses.

COMMUNIST PARTY FIRST: How old was the

bride and

HON. MR. MICHOIS: But we are finding

that as a result of these improved facilities a great

many of our people who have been living alone have better

food, and are going to be living longer, but we also have

the problem that at some point people need care that is

not available. There are hospitals, and the arrangements

are that our government has provided arrangements in one

of our psychiatric centres for those who cannot care for

themselves in one of the hospitals. We have three centres,

Kelowna, Victoria and Vancouver, where we share with the

Federal Government under the shared hospital program

in Kelowna, in a fourth centre, we have

a psychiatric centre which is not shared, where people

do not require such active care.

I have some of my officials here who I

think might appreciate Mr. Michois's work particularly,

in this field. Mr. Michois is the head of the hospital

and home division. Perhaps I might ask Mr. Michois if

he would care to supplement what I have said regarding

the availability of care for the group of elderly people

in such general hospitals. Some are in one hospital, who

require more active nursing care, and Mr. Michois, our



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2
3 Director, might also wish to supplement what I have said.

4 DR. KOBRYNSKI: The geriatric centres are
5 in fact long-care institutions, providing extensive
6 nursing care under supervision. There are three centres
7 which are under the Federal-Provincial scheme, and one
8 which is outside it. Now, the reason why these three
9 were not organized as shareable with the Federal Govern-
10 ment was that they were intending to function as so-called
11 chronic hospitals, but the admission policy to the geria-
12 tric centre is such that all people applying for a bed
13 in a geriatric centre are screened by a Screening Committee,
14 where two of the medical doctors are present, and a
15 social worker. If their condition is such that they
16 require treatment at one of the three geriatric centres,
17 they are put on a waiting list, and when a bed is available
18 they are admitted. The waiting period is variable. In
19 Melfort, for example, there are vacancies for males
20 immediately. For females there is still a waiting period.
21 In Regina unfortunately there is a longer waiting period
22 for male patients of six to eight months. For a female
23 patient it takes as long as 18 months. However, we
24 noticed recently rather a decrease on the waiting list.
25 About a year ago it was 230, 240 on the waiting list.
26 Right now we have 207.

27 There is also another quite peculiar
28 trend, that some families are rather keeping their
29 disabled people at home, and therefore let us say we have
30 about 36 on the waiting list where the families put their
name on the waiting list but do not want to put them in
the centre right now, because they feel they can care for

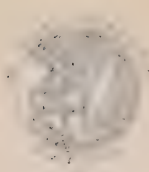


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3 them at home. It is a rather good sign.

4 As far as treatment is concerned, the
5 geriatric centres, when they were established, according
6 to the trend at that time, they were instituted as
7 custodial care institutions for permanent care. However,
8 when I started my work about two years ago, I noticed
9 that the length of stay of people in the geriatric
10 centres, and particularly in Regina, was about three
11 years, so therefore it couldn't be considered, you cannot
12 consider a permanent case with a length of stay of three
13 years. That is the average length of stay, therefore
14 we were faced with the problem what to do with people
15 who remain in a so-called custodial care institution for
a long time.

16 After visiting centres in Britain and the
17 United States, where you have, I submit, it is a new
18 program which was partially accepted, and it was the
19 program of geriatric rehabilitation. Taking into consi-
20 deration the state into which the people were getting,
21 which is really extremely disabled, we could only establish
22 a modest program. The aims of the program was to prevent
23 further deterioration. That was the primary one. When
24 possible achieve certain improvements. Well, finally
25 to salvage what is left. That is probably the best way
to put it.

26 I am glad to see that in spite of great
27 pessimism we did achieve certain results, not much. I
28 had the opportunity to place a paper at the last Saskat-
29 chewan Medical Association convention. It looks now,
30 according to authorities, that we were in fact, there



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4 was too much pessimism with regard to elderly people and
5 the possibility for their recovery. They do recover to
6 some extent if proper measures are implemented at the
7 proper time. The proper time is extremely important.
8 Too late the best treatment can do nothing. So far as
9 in Saskatchewan, I would say that we still have a gap
10 between the general hospitals and the geriatric centres.
11 We don't reach people at an earlier stage at the time
12 when they should be reached. We have excellent facilities
13 for acute diseases in general hospitals, and we have, well,
14 satisfactory facilities for people who are extremely
15 disabled in the geriatric centres. Now, from the patients
16 we are admitting in the geriatric centres, from my own
17 observation and the observation of other people, is that
18 if we were to get them at an earlier stage we would do
19 a better job, so therefore I suppose we should try to do
20 something in this direction.

21 There is one more point, whether or not
22 we really need more and more beds to do the job. Whether
23 or not we should build more and more institutions. This
24 is in fact a controversial subject, but it looks like
25 rather as if the trend is to try to do everything to keep
26 the people in their own homes as long as it is possible,
27 but I feel that what we should do is try to help the
28 families financially, as well as through other measures,
29 like visiting therapists, visiting nurses, home economics
30 services, in such a way as to facilitate the families to
keep them home, because as far as I can see from the
waiting list of 36 who don't go to the centres there are
families who wish to keep the patients at home, but there

was too much pessimism with regard to elderly people and
the possibility for their recovery. They do recover to
some extent if proper measures are implemented at the
proper time. The proper time is extremely important.
Too late the best treatment can do nothing. So far as
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the people in their own homes as long as it is possible,
but I feel that what we should do is try to help the
families financially, as well as through other means,
like visiting therapists, visiting nurses, home economists
services, in such a way as to facilitate the families to
keep them home, because as far as I can see from the



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3 are instances where they just cannot do it.

4 COMMISSIONER FIRESTONE: You were
5 mentioning, Doctor, that you have prepared a paper which
6 summarized the experience that you have had in Saskat-
7 chewan in this field. Could a copy of that paper be
8 made available to the Commission, so that we can learn
9 more about this experience you have had here in Saskat-
10 chewan?

11 DR. KOBRYNSKI: This is a clinical paper,
12 well, I demonstrated certain clinical cases. There is
13 no statistical data. It is a medical paper, but I will
14 be glad to submit it.

15 COMMISSIONER FIRESTONE: I am sure it will
16 be particularly helpful to our medical colleagues on the
17 Commission, and our Medical Consultant. I had hoped it
18 might include things that the layman might find useful,
19 because we are trying to learn more about your experience.
20 It is a novel experiment and it deserves to be studied,
21 and perhaps, Mr. Minister, that paper, which is largely
22 medical, could be supplemented with descriptive and
23 qualitative material. It might give the Commission some
24 ideas which might be applicable to the rest of Canada.

25 HON. MR. NICHOLSON: Yes, I am sure that
26 Dr. Kobrynski will be glad to add supplemental information
27 that his Minister might appreciate as well. I might file
28 with you our report to the end of 1960. We have the
29 1960-61 available, but it has not been filed yet. We
30 make a maintenance grant of \$40 a year for the self-
contained units that Central Mortgaging and Housing are
connected with, and for the housing centres we make a



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4 \$60 a year grant, and no one is barred for the lack of
5 funds. If the old-age pension is inadequate, we have a
6 sharing plan with the Federal and municipal authorities,
7 so no one is barred for lack of funds. I will be glad
8 to file this at this point, and as soon as the latest
9 report is tabled it will be forwarded.

10 THE CHAIRMAN: This will be Exhibit 108.

11 --- EXHIBIT NO. 108: Annual Report, 1959-1960, Depart-
12 ment of Social Welfare and Rehabili-
13 tation, Province of Saskatchewan.

14 THE CHAIRMAN: Mr. Nicholson, there are
15 spare copies of that?

16 HON. MR. NICHOLSON: Yes.

17 THE CHAIRMAN: If they could be sent to
18 Ottawa...?

19 HON. MR. NICHOLSON: When the new one has
20 been tabled we will make several copies available.

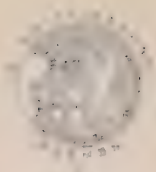
21 THE CHAIRMAN: We should have 25.

22 HON. MR. NICHOLSON: We will be able to do
23 that.

24 DR. KOBRYNSKI: I have a brief here on
25 geriatric rehabilitation in Saskatchewan.

26 COMMISSIONER FIRESTONE: This would be
27 most welcome.

28 HON. MR. NICHOLSON: This was submitted
29 by Dr. Kobrynski in April 1961 to the Age and Long-Term
30 Illness Survey Committee.



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\$60 a year grant, and no one is barred for the lack of funds. If the old-age pension is inadequate, we have a sharing plan with the Federal and municipal authorities, so no one is barred for lack of funds. I will be glad to take this at this point, and as soon as the latter report is received it will be forwarded.

THE CHAIRMAN: This will be handled; yes.

--- Exhibit No. 104: Annual Report, Department of Health and Human Services, Division of Research, 1961.

THE CHAIRMAN: Mr. Nicholson, would you have copies of that?

THE CHAIRMAN: If they could be sent to

HON. MR. NICHOLSON: When the new one has been tabled we will make several copies available.

THE CHAIRMAN: We should have it.

COMMISSIONER FIRST: This would be

HON. MR. NICHOLSON: This was a letter by Dr. Koscynski in April 1961 to the Age and Longevity



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4 --- EXHIBIT NO. 108A: Copy of a brief concerning
5 geriatric rehabilitation in
6 Saskatchewan submitted to Age and
7 Long-Term Illness Survey Committee,
8 April 1961.

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10 COMMISSIONER FIRESTONE: You anticipated
11 my next question when you were offering some statistics
12 as to the subsidies that you are offering to hostels.
13 You explained to us how the capital costs of these
14 hostels are financed: 72% Federal Government; 8%
15 community; and 20% from the Provincial Government. How
16 are the operating expenses of these hostels covered?

17 MR. CHALMERS: Might I say first, Mr.
18 Chairman and Dr. Firestone, that I should probably give
19 you a little background of these hostels first, so you
20 will get an idea of how the growth of these has progressed.
21 In 1944 there were just six of these institutes in the
22 Province of Saskatchewan with about 360 beds. These
23 were church institutions such as St. Andrew's Home in
24 Moose Jaw. This situation prevailed pretty well up into
25 the 48's and 49's when there was very little effort made
26 towards housing the senior citizens. Since about 1953
27 when the Provincial Government announced the policy of
28 20% grants and the maintenance grants, there has been a
29 tremendous growth in these hostels and homes and self-
30 contained units for independent living for couples and
bachelor suites. At the present time there are 48 hostel
and housing projects with 2,049 beds available for nursing
people and those who require some supervisory care.
There are 39 projects with self-contained units with
1,966 beds, for a total of 4,105 beds at this time. This



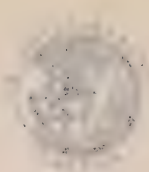
--- EXHIBIT NO. 1087: Copy of a brief concerning
geriatric rehabilitation in

long-term illness survey Committee
April 1961

my next question when you were offering some statistics
as to the subsidies that you are offering to state
commentary, it is not clear that the subsidies are
are the operating expenses of these facilities covered
Mr. Chalmers: Right, I am sorry, Mr.
Chalmers and Mr. Thirsk, that I should clarify
you a little later, none of it is covered, but as you
will get an idea of the extent of these facilities
in the areas where I am talking, these facilities in the
Province of Saskatchewan with about 300 beds, these
were church institutions such as St. Ann's, and in
some cases, this situation prevails pretty well up into
the 40's and 50's when there was very little support made
towards housing the elderly, and about 1963
the 40's and the 50's, and the 60's, as far as I am aware
remained almost in the same state, and some and self-
contained units for independent living, the houses and
apartment suites. At the present time there are 28 percent
and housing projects with 1,000 beds available for nursing
people and those who require some supervisory care.
There are 33 projects with self-contained units with
1,000 beds, for a total of 1,100 beds at this time. This



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3 fluctuates from day to day as beds are increased or
4 decreased. I would also point out that in the geriatric
5 centres there are 650 beds all told -- this is the
6 provincial geriatric centres. Each one of these housing
7 projects are operated by organizations or municipalities
8 on a non-profit basis. I didn't include three commercial
9 homes that are operating as commercial ventures: two in
10 Saskatoon, and one in Tuxford. These homes provide
11 certain services to people at their own cost in accor-
12 dance with the amount of funds they require for their
13 own profit. The other homes are voluntary homes operated
14 without profit, and the rates are set for the maintenance;
15 rates are set to the point where they will cover the
16 cost of operation each year. In other words, if they
17 found \$61 a month per person to be the figure, then,
18 this is what the rate is throughout. The rates range
19 from \$65 to \$125 a month depending on the hostel or the
20 home or the type of care being provided. Some of these
21 homes provide care almost similar to that provided in a
22 rehabilitation centre. Others are simply providing
23 custodial or supervisory care. The method by which the
24 people who enter the homes pay the maintenance rates
25 is based on their ability to pay, and if they do not
26 have the necessary financial ability to pay they may
27 then apply either through the Department of Social Welfare,
28 if they are over 70 years of age, for a supplementary
29 allowance, or the means test program, or through their
30 local municipalities or social aid. These two programs
are under Mr. Sihvon's branch. But, no person needs to
be refused accommodation because they don't have the \$65



fluctuates from day to day as beds are increased or decreased. I would also point out that in the psychiatric centres there are 650 beds all told -- this is the provincial psychiatric centres. Each one of these housing projects are operated by organizations or municipalities on a non-profit basis. I think there are three commercial homes that are operating as commercial ventures: two in Saskatoon, and one in Laxford. These homes provide certain services to people at their own cost in accordance with the amount of funds they require for their own profit. The other homes are voluntary homes operated without profit, and the rates are set for the maintenance; rates are set to the point where they will cover the cost of operation each year. In other words, if they found \$61 a month per person to be the figure, then, this is what the rate is throughout. The rates range from \$65 to \$115 a month depending on the cost of the home on the type of care being provided. Some of these homes provide care almost similar to that provided in a rehabilitation centre. Others are already providing custodial or supervisory care. The method by which the people who enter the homes pay the maintenance rates is based on their ability to pay, and if they do not have the necessary financial ability to pay they may then apply either through the Department of Social Welfare if they are over 70 years of age, for a supplementary allowance, or the means test program, or through their local municipalities or social aid. These two programs are under Mr. Stinson's branch. But, no person needs to be refused accommodation because they can't have the \$65



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3 or the \$125. There are ways and means they can get it
4 if they can show need.

5 COMMISSIONER FIRESTONE: This looks like
6 a very progressive program.

7 COMMISSIONER VAN WART: Do you detain
8 their old-age cheque when they enter the home?

9 MR. CHALMERS: No, they are permitted to
10 deal with their own finances, if they are capable of
11 doing so.

12 THE CHAIRMAN: You mean physically?

13 MR. CHALMERS: Yes, physically or mentally.

14 COMMISSIONER VAN WART: You take no propor-
15 tion of their old-age cheque?

16 MR. CHALMERS: No. They are expected to
17 pay their monthly payments through their own resources,
18 or whatever resources they have available to them.

19 COMMISSIONER FIRESTONE: This looks like
20 a very progressive program, and I am sure it must have
21 been very helpful to the 4,000 elderly citizens involved.
22 I am just wondering whether as large as the number of
23 4,000 sounds, whether it is an adequate number to take
24 care of the increasing number of elderly citizens that
25 the Province of Saskatchewan and all other provinces
26 have?

27 HON. MR. NICHOLSON: No, we don't think
28 it is adequate, but we are working in a relatively new
29 idea, and there are some people who undoubtedly would be
30 more comfortable in this type of facility than living
on their own, and they prefer to be on their own and
the families and the neighbours cannot persuade them to



on the \$125. There are ways and means they can get it if they can show need.

COMMISSIONER WILSON: This looks like

COMMISSIONER VAN WART: Do you detain

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MR. CHAIRMAN: You mean physically?

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3 make the change, but we do expect as the years go by --
4 there is hardly a month but what we are having representa-
5 tions from centres in the community wondering if we will
6 send our Mr. Chalmers and members of the staff out to
7 discuss the program and find out if there is enough need.
8 Some people with cash assets of \$10,000 tie up most of
9 that money in buying a house in town, whereas he and his
10 wife could go into one of these centres and for \$40 a
11 month have much better accommodation. However, the tradi-
12 tion is that paying rent is money down the drain, and
13 so they would rather tie up all their cash and move into
14 their own house.

15 COMMISSIONER FIRESTONE: I take it from
16 what you say you rely on the initiative being taken
17 either locally by a church organization or by a municipa-
18 lity? The initiative is not taken by the Provincial
19 Government?

20 HON. MR. NICHOLSON: It is not. We provide
21 the technical know-how. We negotiate with Central Mort-
22 gage and Housing since they are going to present 62% of
23 the capital. They want to know, for example, if the
24 Kamsack area is a potential need and whether people are
25 in the age or economic group that they cannot go to
26 Florida, and whether they would make use of these.
27 Roughly, there is a negotiating period of two years with
28 the community to decide they would like to do this. When
29 Saskatchewan celebrated its golden jubilee in 1955 there
30 was a tremendous amount of community interest in honouring
our pioneers by providing this type of facility. If the
Commissioners were to be longer in the province we would



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3 like you to see some of these. I am sure the Chief
4 Justice knows of the ones in Saskatchewan.

2 5 COMMISSIONER FIRESTONE: It has been
6 suggested to us by some of the hospital administrators
7 that people are occupying hospital beds perhaps for
8 longer periods than would be required on purely medical
9 grounds, and the reason given is that it was difficult
10 to discharge them when these people had no place to go.
11 They mentioned some cases that required home care, and
12 some might require institutional care, and the question
13 arises, how can this problem be resolved? We were given
14 to understand that if a person were to be kept, say, as
15 you suggested, in one of those senior citizens' homes,
16 even with some home care, it would involve something like
17 \$120 a month. That would work out to about \$4 a day.
18 Now, keeping these people in a hospital costs on an
19 average perhaps \$20 a day. In other words, the problem
20 which one faces is whether one could make more facilities
21 available -- this is purely an economic problem; partly
22 a problem of application, and some of the things we
23 might learn -- but, the question arises, wouldn't it make
24 more economic sense to spend \$4 for a senior citizen in
25 one of these hostels with home care than keeping that
26 person in a hospital bed which costs \$20 a day? If you
27 were to apply the former method there might be a saving
28 to governments, and thereby the taxpayer, of something
29 like 400% -- the difference between \$4 a day and \$20 a
30 day. It seemed to us that while you have made perhaps
more strides than any other province, there seems to be
still a gap existing, and I think Dr. Kobrynski pointed

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to understand that if a person were to be kept, say, as

you suggested, in one of these senior citizens' homes,

even with some home care, it would involve something like

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average perhaps \$20 a day. In other words, the problem

which one faces is whether one could make more facilities

available -- this is purely an economic problem; partly

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3 to this gap. We would like to know some specific ways
4 in which one could bridge that gap. We are thinking not
5 only in terms of Saskatchewan, but we are hoping from
6 your experience you could offer us advice which we
7 could apply on a broader and national basis.

8 HON. MR. NICHOLSON: Mr. Chairman, I think
9 this has been one of the most helpful questions that has
10 been asked all week, at least from my point of view, and
11 in replying I would like to say that we are having active
12 discussions with the Federal Government and the local
13 groups involved in this problem. In one of the hostels
14 there is a former matron of the hospital, who was a great
15 help until she had a stroke, and the others in the hospi-
16 tal would like to have her continue there for a longer
17 period, but a point is going to be reached where she will
18 have to get other care, and we would like the Federal
19 Government -- and there is some difference of opinion as
20 to whether the Department of Health and Welfare or the
21 Central Mortgage and Housing should be the department
22 that would be involved -- but we think that for these
23 communities, where there has been participation on a
24 municipal, provincial and federal basis, that we should
25 go a step further and provide the intermediate care which
26 Dr. Kobrynski mentioned. I might say, having discussed
27 this matter with both Health and Welfare and Central
28 Mortgage and Housing, there is a great deal of interest
29 and sympathy. Dr. Firestone will be familiar with the
30 discussions that preceded the Federal Government being
involved in the housing job. It was originally assumed
Central Mortgage and Housing was involved in housing but



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3 not welfare, and since there is some welfare involved it
4 was suggested perhaps another, other than Central Mortgage
5 and Housing, were involved. But, since 1953 Central
6 Mortgage and Housing have been involved, and at some
7 point I hope we will be able to have joint participation
8 in providing some intermediate care. There are people
9 who would like to stay in these hostel communities, in
10 the nursing homes, for as long as they can, and here is
11 a field where, I am sure, we will be moving in this
12 direction just as soon as the dollar crisis can be solved
13 and we can get participation by the three levels of govern-
14 ment.

15 COMMISSIONER FIRESTONE: (Mr. Minister,
16 this is a very constructive reply, and I am wondering
17 whether it would be possible for you to spell out in some
18 specific terms at a later stage -- not necessarily right
19 now -- as to what program you would visualize for such
20 intermediate care with participation by all three levels
21 of government. You understand, as a Royal Commission
22 concerned with health services, we are trying to formulate
23 advice which we can pass on to the Federal Government,
24 and if we could have your specific proposals in terms of
25 what kind of program and the kind of participation -- how
26 many involved, in the case of Saskatchewan -- it would
27 enable us to formulate our own views, and based on what-
28 ever advice we may decide upon to the Federal Government,
29 and while we cannot offer you any assurance that the
30 Federal Government will listen to the advice we give them,
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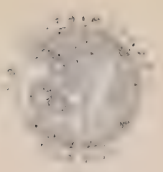


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3 HON. MR. NICHOLSON: As I said, we are
4 participating in more than 40 communities in the province
5 in this type of housing and we have an arrangement that
6 when someone reaches the stage when care must be provided
7 that our geriatric centres will take these people on.
8 Some of these 40 communities are quite a long distance
9 from the centres where we have geriatric treatment. We
10 would like to keep Grandma or Grandpa in the community
11 because they have lived here 50 years and we would like
12 to see them. We have had a good deal of pressure from
13 these centres. Again, we provide facilities to give
14 continuing care for those who cannot look after themselves
15 rather than have them go to Regina and Saskatoon and we
16 are giving active consideration to this and I would be
17 glad to put something in writing for you in this general
18 field.

19 COMMISSIONER FIRESTONE: This would be
20 very helpful but we look forward really to you offering
21 us some advice for specific proposals that you have
22 perhaps already put forward to the Federal Government,
23 the departments concerned. If you could explain to us
24 what you consider would be a reasonable and desirable
25 federal contribution to a provincial-municipal program
26 in this field. Have you any suggestions to us? "That
27 is what we would like to do; that is what it would cost
28 and that is how we can go about it". Can we have it in
29 this specific sense?

30 HON. MR. NICHOLSON: I have discussed
this problem with my opposite numbers in Manitoba and
Alberta, North Dakota and South Dakota and I think it



participating in more than 40 communities in the province in this type of housing and we have an arrangement that when someone reaches the stage when care must be provided that our geriatric centres will take these people on. Some of these 40 communities are quite a long distance from the centres where we have geriatric treatment. We would like to keep Grandmas or Grandpas in the community because they have lived here 50 years and we would like to see them. We have had a good deal of pressure from these centres. Again, we provide facilities to give continuing care for those who cannot look after themselves rather than have them go to Regina and Saskatoon and we are giving active consideration to this and I would be glad to put something in writing for you in this general field.

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MR. NICHOLSON: I have discussed this problem with my opposite numbers in Manitoba and



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4 would be possible to present some suggestions along the
5 lines you suggest and we will give immediate attention
6 to this.

7 COMMISSIONER FIRESTONE: We will leave
8 the time element to you but this will help us come to
9 grips with the problem. We have heard about this but
10 we have not had any proposals as to how to solve it and
11 with your advanced experience you appear to be well-
12 equipped to advise us.

13 I have one more question which is entirely
14 different from the subject we have so far been discussing;
15 I am referring to the availability of social workers.
16 It has been presented to us that the Province of Saskat-
17 chewan is short of social workers and one of the reasons
18 given to us is the lack of a school of social work in
19 the province. What are the possibilities of establishing,
20 in due course, a school of social work? If the problem
21 is the usual dollar to which you referred a while ago,
22 what financial assistance might be involved in order to
23 proceed with such a school establishment?

24 HON. MR. NICHOLSON: I will let Mr. Talbot,
25 the Deputy, answer this because he is a trained social
26 worker. However, I would say there is a shortage all
27 across Canada and this is one of the problems we are
28 discussing with our opposite numbers; with the Minister
29 of Health and Welfare, a representative from the Depart-
30 ment was a guest for lunch yesterday and this is a typical
thing discussed. There is a shortage all across Canada.
Here is a growing field whose importance has been recog-
nized and we are anxious that the shortage should be dealt



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3 with. Again, we lose trained people to other provinces
4 where the climate seems to be a little more attractive
5 and sometimes to other countries where the chances of
6 travelling are pretty attractive. I will have Mr. Talbot
7 reply specifically to your question.

8 MR. TALBOT: With regard to your question
9 about the possibilities of a school, I do not think I
10 can say what the possibilities are because this would be
11 a decision higher than mine. But, I think at the present
12 time there are two opposing views about a school in
13 Saskatchewan. Many people feel if we do have a school
14 of social work this would really ease the shortage. I
15 do not necessarily approve, I think to some extent it
16 would but we know now about how many people from Saskat-
chewan go to other schools.

17 COMMISSIONER FIRESTONE: How many is that?

18 MR. TALBOT: 25 or 30 from our Department,
19 the Health Department - I have no idea but I think 10 to
20 15 go through on health grants and then students going on
21 their own and it has been said if we did have a school
22 there would be more people to stay within the province
and take this type of training and I believe in this.

23 However, we have talked to the other
24 schools about this and there are differences of opinion
25 in the schools themselves. The school at British Columbia
26 feels they have adequate facilities to serve Saskatchewan,
27 Alberta and British Columbia. The school of Manitoba
28 feel they have not adequate facilities to serve any more
29 than they are at the present time and they need a new
30 school with more facilities to increase their enrolment.



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MR. TALBOT: 25 or 30 from our Department.
the Health Department - I have no idea but I think 10 to 15 go through on health grants and then students going on their own and it has been said if we did have a school there would be more people to stay within the province and take this type of training and I believe in this.

however, we have talked to the other schools about this and there are differences of opinion in the schools themselves. The school at British Columbia feels they have adequate facilities to serve Saskatchewan, Alberta and British Columbia. The school of Manitoba feel they have not adequate facilities to serve any more than they are at the present time and they need a new school with more facilities to increase their enrolment.



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3 I think the problem is really not facilities but whether
4 they would get the bodies. There is a gamble in trying
5 to get people to enter this particular profession. I
6 do not think in social work we have any priority and I
7 do not think we are attracting the people we should be
8 attracting. I think even with a school we might find
9 ourselves with a school and probably not sufficient
10 people to enter the school.

11 COMMISSIONER FIRESTONE: Have you bursar-
12 ies or scholarships or fellowships that make it attrac-
13 tive for potential social workers to enter the field?

14 MR. TALBOT: Yes, we have. I spoke the
15 other evening when I was here to that; would you like me
16 to repeat it?

17 COMMISSIONER FIRESTONE: Yes.

18 MR. TALBOT: In both the Department of
19 Health and the Department of Welfare we have educational
20 grants and bursaries. Our educational grant for single
21 persons is \$250 per month during the academic year plus
22 full dues plus cost of books plus cost of transportation
23 to and from the University. In the case of a married
24 person it is \$250. In the case of a single person it is
25 \$200. This year we have had 20 educational grants and
26 bursaries; they total 20.

27 COMMISSIONER FIRESTONE: They were made
28 available to whom?

29 MR. TALBOT: The educational grants to
30 people we had on the staff but did not have their Bachelor
or Masters of Social Work but who had Bachelor of Arts
degrees, to other people throughout the province or from

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4 other parts of Canada who were interviewed and had the
5 qualifications and who, in our opinion, would make good
6 social workers. We had the two types; people on our staff
7 and to encourage people not on our staff to come and work
8 for us. With these grants there are specific commitments.
9 If training is given for one year a person must agree to
10 work two years for the Department after training. If
11 training is given for two current years they must agree
12 to work for three years for the Department. If they
13 break this commitment they are asked to pay back that
14 portion of the commitment which they did not keep.

15
16 COMMISSIONER FIRESTONE: Would you say
17 if younger people took up social work and they are being
18 trained in British Columbia, Manitoba and Toronto, that
19 you could - a number of them might settle in the areas
20 where they are taking their course and their training
21 and, in essence, not return to Saskatchewan although if
22 they had an opportunity to be trained here they might
23 stay.

24
25 MR. TALBOT: I think this happened in my
26 case because I took my training in British Columbia and
27 stayed there for 14 years and then came back to Saskat-
28 chewan.

29
30 HON. MR. NICHOLSON: While they are on
this, I might say it is one of the topics we are
discussing actively with the National Health and Welfare.
What you say is quite right. Mr. Talbot is a Saskatchewan
boy who chooses the plains in this sort of weather rather
than the rain and the fog in Vancouver. However, a great
many people after taking their training, after fulfilling



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3 their commitments, decided to go some place else which
4 might be more interesting. We believe, since there is
5 a shortage across Canada, since the social worker moves
6 from region to region, the Federal Government should be
7 involved in the training.

8 MR. TALBOT: I think this is one of the
9 advantages of having a school because once the school
10 is located you find agencies going and competing for the
11 staff from the students who are graduating.

12 COMMISSIONER FIRESTONE: You were saying
13 that Manitoba which is your neighbouring province has
14 reached pretty much the peak of their existing facilities.

15 MR. TALBOT: Physical facilities.

16 COMMISSIONER FIRESTONE: Yes, and there-
17 fore if we have a shortage and want to train more social
18 workers in Saskatchewan they won't be able to go to
19 Manitoba because they have reached the peak. If an expan-
20 sion of facilities was required for the prairie provinces
21 would not the natural place be Saskatchewan who does not
22 have facilities at all?

23 HON. MR. NICHOLSON: I would agree.

24 COMMISSIONER FIRESTONE: We are agreed on
25 this principle. What is in the way of establishing a
26 school of social work in Saskatchewan if we agree on the
27 principle?

28 MR. TALBOT: I think, first of all,
29 finances. It is going to require a large output of money.
30 Secondly, I think trained personnel for teachers because
there is a great shortage of people with high academic
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COMMISSIONER FERGUSON: Yes, and therefore if we have a shortage and want to train more social workers in Saskatchewan they don't be able to go to Manitoba because they have reached the peak. If an expansion of facilities was required for the prairie provinces would not the natural place be Saskatchewan who does not have facilities at all?

MR. TALBOT: I would agree.

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4 COMMISSIONER FIRESTONE: You were saying
5 you have met with the Department of Health and Welfare
6 to see whether some program could be developed in which
7 the Federal Government would participate?

8 HON. MR. NICHOLSON: That is right.

9 COMMISSIONER FIRESTONE: I take it from
10 that suggestion that you think perhaps in the back of
11 your mind the possibility of establishing a school of
12 social work in Regina, provided a satisfactory arrange-
13 ment can be made in terms of financing and in terms of
obtaining adequate teaching staff, can be made?

14 HON. MR. NICHOLSON: I think it would be
15 correct to say this has been discussed but I should say
16 we have had a very sympathetic hearing from the federal
17 people and they recognize our need and pay attention.
18 Federal Governments, like all other governments, attempt
19 to make decisions on things of a budgetary nature and
20 the discussion regarding the establishment of the school
21 took place before I joined the Department and there has
22 not been any actual discussion since that time. It was
23 turned down at one time chiefly for the reason Mr. Talbot
24 gave but I think the time has arrived when we would have
25 another look at it. I think we probably should make a
26 proposal to the Federal Government to see whether there
27 would be an interest in the hearing and we thank you for
28 this suggestion which we will act upon.

29 COMMISSIONER FIRESTONE: Now, to come to
30 the end of my questioning, would it be possible since you
feel that perhaps the stage is coming where you might give



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the end of my questioning, would it be possible since you feel that perhaps the stage is coming where you might give



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3 the thing a new look or a second look that if you develop
4 some ideas on establishing a school and have some concrete
5 proposals in mind of what kind of assistance the Federal
6 Government might give, could you let us know what such a
7 proposal would be? We would be interested in knowing the
8 capital cost of establishing a school; secondly, the
9 operating cost of establishing a school; thirdly, the
10 staff requirements; fourthly, any bursary ideas you may
11 have to attract students to the school and fifthly, what
12 kind of contribution you would consider appropriate for
13 the Federal Government to make to such a school either
14 capital-wise, operating-wise or bursary-wise or any
15 combination of the three. Would it be possible to do
16 that?

16 because then HON. MR. NICHOLSON: Yes, we will be very
17 glad to do that. I should say that this is a university
18 field and while Mr. Talbot have been giving evidence it
19 is a matter we would have to discuss with the university
20 authorities. However, we will do that and we think the
21 time has come now when we should reopen the question with
22 the University, with my colleagues in the Government.
23 If we get a dollar and cent idea as to what would be
24 involved we will be very glad to make this available.

24 a hole to the MR. TALBOT: There is one other important
25 point I think we should have for the record that wherever
26 a school is established you have to have a multiplicity
27 of agencies in order to do the field work practice and
28 in these agencies you must have trained personnel who can
29 give supervision to the students. I think this has been
30 one of the things that has been considered here, do we

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MR. WILSON: Yes, we will be very glad to do that. I should say that this is a university field and while Mr. Talbot have been giving evidence it is a matter we would have to discuss with the university authorities. However, we will do that and we think the time has come now when we should reopen the question with the University, with my colleagues in the Government. If we get a dollar and sent it as to what would be involved we will be very glad to make this available.

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3 have enough agencies really in Saskatchewan to give the
4 type of training that is needed?

5 COMMISSIONER FIRESTONE: I suppose if you
6 were to put forward a proposal you would want to offer
7 some comments as well on that?

8 MR. TALBOT: Yes.

9 COMMISSIONER FIRESTONE: Thank you for the
10 full and constructive manner in which you and your
11 colleagues have answered all our questions.

12 COMMISSIONER VAN WART: Have you a commis-
13 sion at the present time investigating the problems of
14 the aged?

15 HON. MR. NICHOLSON: That is right. As a
16 matter of fact, Mr. Talbot should be there this morning
17 because they are having a meeting today and tomorrow.

18 COMMISSIONER VAN WART: Would you see that
19 their report is submitted to the Commission?

20 HON. MR. NICHOLSON: Yes.

21 COMMISSIONER VAN WART: And may I urge
22 that this be made available at as early a date as possible.
23 You are making a submission to this Commission?

24 HON. MR. NICHOLSON: No.

25 COMMISSIONER VAN WART: You are submitting
26 a brief to this Commission?

27 HON. MR. NICHOLSON: No, we are going on
28 invitation to answer any questions that might be involved.

29 COMMISSIONER VAN WART: No, the commission
30 for the aged.

DR. KOBRYNSKI: I submitted a statement to
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4 COMMISSIONER VAN WART: Could we have a
5 copy of your submissions to the commission, that is the
6 commission for the aged?

7 MR. TALBOT: Well, the public ones will
8 be available ---

9 COMMISSIONER VAN WART: We are not asking
10 for any secret documents, just the public documents.

11 THE CHAIRMAN: Purely a matter of house-
12 keeping here, these matters we are talking about, now
13 four or five copies are sufficient; we want them for our
14 research staff.

15 COMMISSIONER McCUTCHEON: I wonder if I
16 could direct this question to Mr. Chalmers? In referring
17 to the hospitals the statement was made if it were non-
18 profit the rate was fixed, a monthly rate and the indivi-
19 duals as long as they are physically and mentally capable
20 of handling their own affairs they handle their own
21 affairs and pay their bills monthly to the hospital.
22 You said, as I recall it, there was no barrier to any
23 person who could not pay but if they were over 70 they
24 applied to the Department of Social Welfare and under 70
25 they applied to the local municipality. I take it those
26 monies that they received in order to supplement whatever
27 other income they had to enable them to pay would be
28 paid under the Public Assistance Act and would be a
29 shareable cost with the Federal Government, provincial
30 and municipality?

MR. CHALMERS: Yes.

COMMISSIONER McCUTCHEON: Your operating
costs would include items for amortization of the advance



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COMMISSIONER McCUTCHON: I wonder if I could direct this question to Mr. Chairman? In referring to the hospitals the statement was made if it were non-

profit the rate was fixed, a monthly rate and the individual as long as they are physically and mentally capable of handling their own affairs they handle their own affairs and pay their bills monthly to the hospital.

You said, as I recall it, there was no barrier to any person who could not pay but if they were over 70 they

applied to the Department of Social Welfare and under 70 they applied to the local municipality. I take it those

monies that they received in order to supplement whatever other income they had to enable them to pay would be

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MR. CHAIRMAN: Yes.

COMMISSIONER McCUTCHON: Your operating costs would include items for amortization of the advance



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3 from Central Mortgage and Housing?

4 MR. CHALMERS: That is right, that is why
5 the rates vary. Some of these church and charitable
6 homes have been built without finances from Central
7 Mortgage and Housing, therefore, there is no amortization
8 and their rates can be as much as \$15 a month lower than
9 in a case where they operate through Central Mortgage and
10 Housing.

3 11 COMMISSIONER McCUTCHEON: Whatever the
12 amortization charge is it is included in your cost?

13 MR. CHALMERS: Yes, they submit an annual
14 audited statement to our Department that we check every
15 year and if the rates are too high, it makes a little
16 profit, we advise them to reduce the rates so they
17 would not show a profit. The profit should include
18 such things as depreciation and so on but if there is
19 an indication that there is a deficit then they are
20 advised the rates should be altered.

21 COMMISSIONER McCUTCHEON: They are altered
22 from time to time in order to keep it as nearly as
23 possible on a break-even basis?

24 MR. CHALMERS: That is right.

25 COMMISSIONER BALTZAN: I think you know
26 we are interested in the needs of people individually
27 and as a whole without any partiality to any direction
28 of thought. We are interested in methods, means and
29 establishing solutions. I would like to direct this
30 question to Dr. Kobrynski and I have to apologize because
I should know better but because I do not know could you
help me out with a definition between hospitals and

from Central Mortgage and Housing?

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3 nursing homes, geriatric centres and hospitals for the
4 chronically ill?

5 DR. KOBRYNSKI: I would like to start with
6 the geriatric centre. The geriatric centre is in fact
7 a misleading name, it does not mean anything; it may mean
8 everything and it may mean nothing. What it means, it
9 is the centre for old people and it all depends on the
10 particular program of the centre. To give an example,
11 in Toronto there is a geriatric centre and Dr. Stewart
12 is the director and this is a centre for research. Now,
13 our geriatric centres, I would say they are rather a
14 higher level nursing home. What is a nursing home is
15 quite a problem because you cannot, if you have a nursing
16 home with a good medical staff, with a good ancillary
17 staff, physiotherapists, etc., you might do a better job
18 than, let us say, in a chronic disease hospital.

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19 Once again, a chronic disease hospital is,
20 let us say, a chronic disease hospital is where people
21 are admitted who require more than 30 days care. Some
22 acute conditions require more than 30 days care, but let
23 us say it is policy. Therefore, I don't think there is
24 any clear definition. Therefore when we are speaking
25 about a particular institution it would be preferable,
26 instead of laboursing this, to outline the program of the
27 institution, then we have an idea of what is done in the
28 institution, because different people are applying
29 different opinions. I suppose, Dr. Baltzan, that you
30 would like to know what we call it in Saskatchewan?

31 COMMISSIONER BALTZAN: Yes.

32 DR. KOBRYNSKI: We do not have any chronic

nursing homes, geriatric centers and hospitals for the

chronically ill

Dr. KOLLYNSKI: I would like to start with

the geriatric center. The geriatric center is in fact a misleading name, it does not mean anything; it may mean everything and it may mean nothing. What it means, it is the center for old people and it all depends on the particular program of the center. To give an example, in Toronto there is a geriatric center and Dr. Stewart is the director and this is a center for research, law,

our geriatric center, I would say they are rather a higher level nursing home. What is a nursing home is quite a problem because you cannot, if you have a nursing home with a good medical staff, with a good auxiliary staff, physiotherapists, etc., you might do a better job than, let us say, in a chronic disease hospital.

Now again, a chronic disease hospital is, let us say, a chronic disease hospital is where people are admitted who require more than 90 days care. Some acute conditions require more than 90 days care, but let us say it is policy. Therefore, I don't think there is any clear definition. Therefore when we are speaking about a geriatric institution it would be preferable, instead of saying that, to define the program of the

Dr. KOLLYNSKI: I would like to know what we call it in Saskatchewan?

Dr. KOLLYNSKI: Yes.

Dr. KOLLYNSKI: We do not have any chronic



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3 disease hospitals right now. We do not have any institu-
4 tion which is called chronic disease hospital. The
5 geriatric centres, the three of them which are under the
6 Hospital Plan, are in fact considered as chronic disease
7 hospitals, because the treatment there is free, as in
8 acute disease hospitals. Whether they are or not, it
9 all depends on the definition what you call them.

Really I wouldn't be able to say. Now, nursing homes
10 again we have charitable organizations providing nursing
11 care, and they are called nursing homes, and that is an
12 institution where a certain amount of nursing is provided.

13 COMMISSIONER BALTZAN: And hostels?

14 DR. KOBRYNSKI: That is an institution
15 for sending people usually where a certain amount of
16 personal care is provided, not too much. As soon as
17 they are disabled they are moved out to a geriatric
18 centre.

19 COMMISSIONER BALTZAN: Are you considering
20 attachment to the general hospital of certain wards to
21 give sort of half-way treatment in case of chronic
22 disease where they need attention, say, in the case of
23 a heart or kidney condition, for only three months or
something like that?

24 DR. KOBRYNSKI: Well, it was in my brief
25 of April 1961, and a copy was submitted here. I outlined
26 that I think we need intermediate care facilities, and
27 one of them is small units attached to general hospitals.
28 However, I outlined there that it should be well known
29 to administrators, the program of such a unit, otherwise
30 they will be, let us say, disposal-type institutions for



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CONGRESSIONAL RECORD: And hospitals?

DR. KOTLIKOFF: That is an institution

for sending people usually where a certain amount of
personal care is provided, not too much. As soon as
they are discharged they are moved out to a geriatric

institution. And you considering

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give sort of half-way treatment in case of chronic

disease where they need attention, say, in the case of

a heart or kidney condition, so only three months or

something like that.

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4 the main general hospital. There is a danger that if
5 we organize such a unit attached to the hospital and
6 the administration is not well aware what is the purpose
7 of the unit, all the long stay cases would just automati-
8 cally be referred to the unit, without providing proper
9 care, therefore the unit should rather be an autonomous
10 unit, where people do not take a bed in a free hospital,
11 but get a certain amount of treatment.

12 COMMISSIONER BALTZAN: You say that admini-
13 stration should be informed?

14 DR. KOBRYNSKI: Yes.

15 COMMISSIONER BALTZAN: Would you also say
16 that the people should be informed of the limitations?

17 DR. KOBRYNSKI: Sure.

18 COMMISSIONER BALTZAN: Mr. Minister, you
19 spoke of things which we all know in your province, and
20 my province, our province. Firstly, of the waiting list,
21 and secondly, of the long stay in the hospital. They
22 are both problems here. My thought is this: how could
23 you advise the public? I think the institutions and
24 the people concerned know the problem, so, for instance,
25 blame is on the hospital, and that they are strict.
26 Committees on long stay are reasonable, that the attending
27 physician acts within certain rules and regulations, but
28 after all this is when we attack the hospitals and physi-
29 cians, etc., etc., somebody under whose control this is
30 not gets the blame. You have heard of that, I am sure?

HON. MR. NICHOLSON: Yes.

COMMISSIONER BALTZAN: And it would be a
great relief if we could have some assurance that the

the main general hospital. There is a danger that if

we organize such a unit attached to the hospital and the administration is not well aware what is the purpose of the unit, and the long stay, would just automatically be referred to the unit, without providing proper care, therefore the unit should not be in a hospital, but a certain amount of treatment.

COMMISSIONER BATHURST: You say that admini-

stration should be also.

COMMISSIONER BATHURST: Would you also say

that the people should be informed of the conditions?

COMMISSIONER BATHURST: In Minister, you

speak of things which we all know in your province, and my province, and I suppose, I think, in your waiting list, and secondly, or the long stay in the hospital. They are both problems here. My thought is, first, how could you advise the public? I think the conditions and the people concerned know the problem, so, for instance, blame is on the hospital, and that they are strict.

Committees on long stay are necessary, that the attending physician says within certain rules and regulations, but after all this is when we attack the hospitals and physicians, etc., etc., somebody else who cannot this is not quite the same. You have heard it there, I am sure?

MR. W. NICHOLSON: Yes.

COMMISSIONER BATHURST: And it would be a

great relief if we could have some assurance that the



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3 public themselves share in this knowledge.

4 HON. MR. NICHOLSON: It would seem as if
5 there is a great deal of educational work to be done in
6 this field, and I am sorry I haven't any quick answer
7 for this question.

8 THE CHAIRMAN: I am afraid we have broad
9 enough terms of reference without going into some of
10 those by-paths which are bothering Dr. Baltzan.

11 COMMISSIONER BALTZAN: Just one final
12 remark, and I will ask you because I know it concerns
13 you as well as the other participants. Nowadays it is
14 very difficult for medical teams to know where social
15 welfare activities and participation begin and end, and
16 where and when their part comes in, but it always seems
17 that somehow or other, under health services, the health
18 service people are always mixed up from the beginning to
19 the end. The social welfare portion is not sufficiently
20 known in their share and contribution to the treatment
21 of all manners of disease, and management and so forth.

22 HON. MR. NICHOLSON: That is so.

23 DR. KOBRYNSKI: With regard to how we can
24 solve the problem, I think there is too much stress, this
25 is my personal opinion now, on more beds as a solution
26 to the problem of the aged, and I feel what we really
27 need is provision of facilities and services, and not
28 put the stress on building more and more institutions.
29 We can learn much from the experience of the psychiatrists,
30 that the answer is not build more and more mental hospi-
tals, but provide better facilities, and this is a
perfect analogy with regard to geriatric care. Provide



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3 services, and not wait till they deteriorate and put
4 them into an institution. Therefore, the answer that
5 for 10,000 disabled people we need 10,000 more beds is
6 a very dangerous one.

7 COMMISSIONER STRACHAN: Do you assume
8 responsibility for the dental treatment of patients in
9 your geriatric centres?

10 MR. CHALMERS: Yes, dental, medical and
11 everything not provided for in the health plan. Our
12 patient must have a hospital card, and all benefits are
13 then provided through the centre.

14 THE CHAIRMAN: Thank you very much, Mr.
15 Nicholson and Mr. Talbot and the other gentlemen who
16 were with you this morning. As I said at the beginning,
17 we are indebted to you for having accepted the invitation
18 to come. We are more indebted now for the assistance
19 you have been to us this morning.

20 HON. MR. NICHOLSON: Thank you very much.
21 We realize you have had a very busy week in Saskatchewan,
22 thank you.

23 THE CHAIRMAN: The next submission is from
24 the Yorkton Union Hospital.
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services, and not wait till they deteriorate and put them into an institution. Therefore, the answer that for 10,000 disabled people we need 10,000 more beds is a very dangerous one.

COMMISSIONER STACHAN: Do you assume responsibility for the dental treatment of patients in your geriatric centres?

MR. CHAMBERS: Yes, dental, medical and

everything not provided for in the health plan. Our patients must have a hospital card, and all benefits are then provided through the centre.

THE CHAIRMAN: Thank you very much, Mr.

Whitford and Mr. Talbot and the other gentlemen who were with you this morning. As I said at the beginning, we are indebted to you for having accepted the invitation to come. We are now indebted now for the assistance you have been so kind to give.

MR. WHITFORD: Thank you very much. We realize you have had a very busy week in Saskatchewan, thank you.

THE CHAIRMAN: The next submission is from the Yorkton Union Hospital.



SUBMISSION OF THE YORKTON UNION HOSPITAL

Appearance: Dr. M.C. Novak

THE CHAIRMAN: Dr. Novak, we are very pleased to see you here this morning, and you have no written submission, and therefore I take it that you want to make a verbal statement?

DR. NOVAK: That is correct. I have brought some notes with me, so, Mr. Chairman and members of the Royal Commission, with your permission I will proceed to make a few remarks, and then possibly you can ask questions if you care to do so. In my opening remarks I would like to state that in your letter of invitation to me I took it to mean that I was to present my own opinions, and not those of the Yorkton Union Hospital.

THE CHAIRMAN: Well, that is true to a degree, but we were also interested in having the statistical background upon which your own opinions are based.

DR. NOVAK: I would like it understood that the opinions expressed are not those of the Union Hospital Board.

THE CHAIRMAN: Yes.

DR. NOVAK: From your letter, I interpret the terms of reference to be utilization of hospital facilities, the relative needs of active, convalescent, and chronic beds, length of stay of patients, waiting periods for admission, beds not used for various reasons, proportion by which daily patient census could be reduced if alternative facilities were available for convalescence, and the home care programs. To that I



The Chairman: Now, however, we are very

pleased to see you here this morning, and you have no
written submission, and therefore I take it that you want
to make a verbal statement.

Mr. [Name]: That is correct. I have

brought some notes with me, so, Mr. Chairman and members
of the Royal Commission, with your permission I will
proceed to make a few remarks, and then I shall
can ask questions if you care to do so. In my opening
remarks I would like to state that as you stated in
invitation to me I took it to mean that I was to present
my own findings, and the views of the Toronto Union
Health.

Mr. [Name]: Yes, that is true as a

general, but we were also interested in having the statis-
tical background upon which you and others are based
and the way in which it was obtained.

That the figures expressed are not those of the Union
Health.

Mr. [Name]: Yes.

Mr. [Name]: From your letter, I interpreted

the report as referring to the utilization of hospital
facilities, the relative areas of active, convalescent,
and chronic beds, length of stay of patients, waiting
periods for admission, fees and other various reasons,
protection by which active patients could be
helped in alternative facilities were available for
convalescence, and the home care programs. To that I



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4 would like to add my own; the cost of chronic and acute
5 care.

6 We in Yorkton are in somewhat a unique
7 position, in that we have two hospitals operated by the
8 same Board of Governors, and under the one administrator.
9 The main hospital in the city is used for the acutely
10 ill, while the auxiliary hospital, which was originally
11 R.C.A.F., is utilized as much as possible principally
12 for the chronically ill, though at times an overflow
13 from the acute hospital does go there. Separate records
14 are maintained in each hospital for accounting and statis-
15 tical purposes, and it thus gives us an opportunity to
16 compare the operation of the two hospitals, so my remarks,
17 therefore, this morning, are going to be based on these
18 records, plus the opinions I express, will be based on
19 those records, and as well on my, shall I say, over 20
20 years experience as a practising physician in these hospi-
21 tals, and subsequently as administrator for five years.

22 Now, in dealing with the first point that
23 was rather vague to me, utilization of hospital facilities,
24 I take that to mean the percentage occupancy and so on in
25 our particular area. Our occupancy is for the most part
26 about 100%, and sometimes well over a hundred, in that we
27 have beds at times, and a number of them set up in
28 corridors, so hospitalization there is for the most part
29 about 100%, and with respect to laboratory and x-ray
30 facilities, they are equally taxed to the limit.

31 The relative need for active and convales-
32 cent chronic beds, I don't think that I can make a very
33 clear statement here. In the acute hospital we have 122



would like to end my own, the cost of inpatient and acute
care.

We in London are in somewhat a unique
position, in that we have two hospitals operated by the
same Board of Governors, and under the one administrator.
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ill, while the auxiliary hospital, which was originally
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for the chronically ill, though at times an overflow
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an particular area. For occupancy is for the most part
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corridors, so that at times there is for the most part
about 100%, and with respect to occupancy and x-ray
facilities, they are equally taxed to the limit.

The relative need for active and convales-

cent chronic care, I don't think that I can make a very
clear statement here. In the acute hospital we have 112



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3 beds. In the auxiliary or chronic one, 50 beds, and as
4 I stated, they are both occupied most of the time, so
5 if you take these figures to mean anything, I would say
6 that we require one chronic bed to every two acute beds.

7 Looking at it in another way, if you take
8 the patient days, by the way, I calculated to show that
9 I am basing these figures on reviewing our records for
10 the immediate past three years, looking at patient days
11 I find that the average in acute for three years was
12 30,412. For chronic it was 17,328. Again indicating
about one chronic bed to two acute beds.

13 Now the effect of geriatric medicine.
14 We are beginning to have an aging population in this
15 country. We are no longer a young country in that
16 respect, and also with the improved medical geriatric
17 care we are beginning to carry our older citizens to a
18 riper old age. That too tends to increase the number of
19 those who will require longer care, and thus, in my
20 opinion, there will be a greater demand for chronic beds
21 in the future, as time goes on. I would like to mention
22 the effect of senior citizens' homes on the acute bed
situation. We have that problem as well in Yorkton.
23 We have a senior citizens' home housing some 150 people,
24 and I understand that there is a waiting list as well.
25 Now, our problem, and it is becoming more acute from year
26 to year, is this: that people who come to this home are
27 naturally those who will be requiring in the not too
28 distant future in many cases, possibly not acute care,
29 but hospital care of some nature. Our senior citizens'
home has no provision whatever for nursing care, and there
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3 is no intermediate step between the senior citizens'
4 home and the acute hospital. We are finding that we
5 are getting an increasing number of long stay cases,
6 and even at a time when this long stay case is ready to
7 go he or she may have spent a month, two, or three months
8 in a hospital, or even in a chronic hospital. Their
9 place has been taken up in the senior citizens' home,
10 and this person too by the way is dislocated. He has
11 nowhere to go, so there is the problem. For that reason
12 I submit again that there must be some intermediate
13 step between the senior citizens' home and the acute
14 hospital.

14 Another point I would like to deal with,
15 and here I am entering on very dangerous ground. I
16 would like to predicate my next remarks that what I say
17 is not by way of criticism of any one person, or any
18 group of persons. I want to deal with the fact of misuse
19 of acute beds. As you know, in this province we have the
20 Saskatchewan Hospital Service Plan, and for a certain
21 fee, or tax, we get what we call a hospital card.
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4 That entitles us to hospital care, if
5 required, in any hospital in the province and also outside
6 the province. It provides all hospital facilities, or
7 medicines, with a few exceptions, diagnostic facilities at
8 no charge to the patient, but it does not include diagnostic
9 facilities for the out-patient -- for the ambulant patient.
10 To get around that, patients are frequently admitted by
11 physicians who could have had their diagnostic work done,
12 whether it be x-ray or laboratory, on an out-patient basis
13 for which they would have to pay; but to get around that,
14 the patient is admitted to the hospital and occupies an
15 acute bed, in our case at about \$20.00 a day. So, the
16 government is put to the expense of \$20.00 a day for the
17 bed plus the cost of whatever diagnostic procedures have
18 been made. As an illustration of that, I would like to quote
19 two very recent cases. Admission diagnosis: Unresthenia --
20 and I am not quite clear what that is. On discharge the
21 diagnosis was the same. During the four or five days --
22 and by the way, this patient was about 16 or 17 years old
23 -- during the four or five days stay, this is what was done:
24 X-ray, gall bladder series, intrainintestinal series; electro-
25 cardiogram, chest plates, white blood count; red blood count.
26 At no time was any treatment prescribed. The patient was
27 discharged. The only thing the patient received was
28 effervescent phosphate, which is a kin, I suppose, to Eno's
29 Fruit Salts.

30 THE CHAIRMAN: Dr. Novak, could you give an
estimate of the cost of that procedure?

DR. NOVAK: Yes, in this case four days at
\$20.00 for the bed, plus \$55.00 for diagnostic procedures.

COMMISSIONER VAN WART: There is no mention



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3 of the psychiatric treatment the patient received?

4 DR. NOVAK: No. I could only read the
5 nurse's notes. The first note on her nurse's sheet: "The
6 patient states he is in for investigation".

7 COMMISSIONER FIRESTONE: On that point, if
8 you had treated the patient in the out-patient facility,
9 what would have happened?

10 DR. NOVAK: If you don't mind, I will state
11 the next case first.

12 COMMISSIONER FIRESTONE: Very well.

13 DR. NOVAK: This patient was admitted with
14 a diagnosis of collistitis -- gall bladder disease. During
15 the patient's six day's stay, this is what was done by way
16 of x-rays: Chest, kidneys, stomach, gall bladder; complete
17 blood count, and so on. There was no treatment given except
18 the patient was, in the middle of this investigation,
19 permitted to dress and go downtown. I don't know what for
20 -- shopping or something like that -- and then came back.
21 That was a cost of \$120.00 for the bed and \$63.00 for
22 investigation.

23 COMMISSIONER FIRESTONE: In that case it cost
24 \$183.00?

25 DR. NOVAK: \$183.00.

26 COMMISSIONER FIRESTONE: If that patient
27 had been treated or examined or investigated ---

28 DR. NOVAK: It would have cost \$63.00. The
29 point I am trying to make is I firmly believe that along
30 with hospital care for the in-patient and free diagnostic
investigation when in hospital I think that the out-patient
diagnostic facilities should also be free.

COMMISSIONER FIRESTONE: In other words, you

of the psychiatric treatment the patient received?

DR. HOWARD: No, I could only read the

notes. The first note on her nurse's sheet: "The

patient states he is in for investigation."

COMMISSIONER FIRSTMAN: On that point, if

you had treated the patient in the out-patient facility,

that would have happened.

DR. HOWARD: If you don't mind, I will state

COMMISSIONER FIRSTMAN: Very well.

DR. HOWARD: This patient was admitted with

diagnosis of colitis -- gall bladder disease. During

the patient's stay, this is what was done: x-ray

x-ray: Chest, abdomen, stomach, gall bladder; complete

physical exam, and so on. There was no treatment given except

the patient was, in the middle of this investigation,

admitted to dress and go down. I don't know what for

shopping or something like that -- and then came back.

There was a cost of \$10.00 for the bed and board for

COMMISSIONER FIRSTMAN: In that case it cost

has been treated or examined or investigated --

DR. HOWARD: It would have cost \$20.00. The

what I am trying to make is I firmly believe that along

with hospital care for the in-patient and free diagnostic

investigation when in hospital I think that the out-patient

diagnostic facilities should also be free.

COMMISSIONER FIRSTMAN: In other words, you



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4 are saying if the out-patient facilities had been used
5 the hospital would have saved about 200 per cent of the
6 cost?

7 DR. NOVAK: Yes.

8 THE CHAIRMAN: You are saying if they were
9 covered there would not be an inclination to go into
10 hospital?

11 DR. NOVAK: That is true. I am not trying
12 to lay the blame on the profession, nor on those who
13 administer the plan, except this I know: During my period
14 of administration -- and I also questioned my accountant
15 on this, and he was there ten years before I was -- at no
16 time were these cases unpaid by the Saskatchewan Hospital
17 Services Plan. These bills were submitted by the hospital
18 and paid.

19 THE CHAIRMAN: You mean they were not
20 questioned?

21 DR. NOVAK: On one or two occasions they
22 were questioned, but finally paid. These are not isolated
23 cases. I can't tell you how prevalent that practice is,
24 but it certainly is not uncommon.

25 As to length of stay in an acute hospital,
26 and over a period of three years, the average is 8.42 days,
27 which, I think, is very good; in the auxiliary, 12.41
28 days over the same period. Combining these two figures or,
29 in other words, if both hospitals were under the same roof,
30 the length of stay over the same period would be 10.4 days,
or approximately two days longer per patient.

THE CHAIRMAN: Do you have the same per
diem rate in both sections?

DR. NOVAK: Insofar as the Saskatchewan



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4 Hospital Services Plan is concerned, yes, but the costs
5 are not the same. In our acute hospital our costs are
6 much higher -- the per diem rate; in the chronic, so much
7 less. I will come to that later on.

8 Waiting periods: I presume we refer to
9 elective cases here: Approximately one month. At certain
10 periods of the year we have as many people on the waiting
11 list as there are patients in the hospital.

12 Beds not used for various reasons: About
13 the only thing I can refer to here is our isolation ward
14 in which we have either six or eight beds -- I forget
15 which. These beds are certainly not used at all times.
16 I doubt if they are used 50% of the time, but it is an
17 isolation ward and it is not used for any other purpose.
18 I do not think we should have isolation wards as such. We
19 are in the process of completing our new hospital which we
20 shall be occupying before too long, and in it on each
21 nursing unit there is a unit of one private and two semi-
22 private beds, connected by a utility room, and either one
23 or both rooms could be completely closed off and used for
24 isolation purposes, when required. When not required,
25 they are used for general purposes. I don't know how this
26 will work out, but it sounds very good in theory.

27 The proportion by which daily census could
28 be reduced if alternative facilities were available for
29 convalescent and chronically ill: Again, I can only refer
30 to our bed occupancy, and it would indicate that 33% -- if
we had a chronic hospital. And I presume your question
is, the percentage by which daily census would be reduced
in an acute hospital?

THE CHAIRMAN: Yes.



Hospital Services Plan is concerned, yes, but the costs are not the same. In our acute hospital our costs are much higher -- the per diem rate, in the chronic, so much less. I will come to that later on.

Waiting period: I presume we refer to elective cases here: Approximately one month. At certain periods of the year we have so many people on the waiting list as there are patients in the hospital.

Is this used for various reasons: About the only thing I can recall to have is our isolation ward in which we have six or eight beds -- I forget which. These beds are very rarely used at all times.

I don't know how many of the time, but it is an isolation ward and it is not used for any other purpose. I do not think we should have isolation wards as such. We are in the process of building our new hospital which we

will be occupying before too long, and in it on each nursing unit there is a unit of one private and two semi-private beds, connected by a hallway room, and either one or both rooms could be completely closed off and used for isolation purposes, when required. When not required, they are used for general purposes. I don't know how this

will work out, but it sounds very good in theory.

The proportion of which daily census could be reduced if alternative facilities were available for convalescent and ambulatory care. Again, I can only refer to our own experience, and it would indicate that 35% -- 40%

we had a chronic hospital. And I presume your question is, the percentage by which daily census would be reduced in an acute hospital?



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3 DR. NOVAK: I would say about 30%. That
4 is based on our figures. As to costs, I told you that we
5 have a single per diem rate from the Saskatchewan Hospital
6 Services Plan, and last year it was \$16.11. In the acute
7 hospital our cost was \$20.80 -- that is, per patient day;
8 in the chronic, \$12.41. This indicates that if there are
9 no facilities for the chronically ill you are keeping a
10 chronic patient in a \$20.00 bed whom you could have kept
11 on \$12.00.

12 Referring to home care programmes, we have
13 no experience in that, and here again I am not quite
14 certain what you mean. If you mean hospital based home care
15 programmes, we have no experience in that. I would like
16 to refer the Commission to the experience of Vernon,
17 British Columbia, and they have a home care programme there.
18 That is the only one I know of in Western Canada. I cannot
19 visualize it being a practical thing in a small centre.

20 Mr. Chairman and members of the Commission,
21 this is all I have to say.

22 THE CHAIRMAN: Dr. Novak, we are indeed
23 very grateful to you for having accepted our invitation to
24 give us the information on these questions which were sent
25 to you, and there may be one or two questions here but, as
26 you will appreciate, we have asked for explanations as we
27 went along.

28 DR. NOVAK: Yes.

29 COMMISSIONER BALTZAN: Just one question,
30 Dr. Novak: Have you got an admitting committee in your
hospital?

DR. NOVAK: We had, but it wasn't practical
-- or, non-functional.



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3 COMMISSIONER BALTZAN: In other words, it
4 is not very much help?

5 DR. NOVAK: No. I don't think, Doctor,
6 what I said, particularly with respect to misuse of beds --
7 I don't think Yorkton is an isolated case. I think this
8 practise must be prevalent -- in fact, I have reason to
9 believe in other areas it is worse than it is in Yorkton.

10 COMMISSIONER STRACHAN: How many physicians
11 have you?

12 DR. NOVAK: I think sixteen -- that is, on
13 the actual staff. There are others such as the medical
14 health officers; and in the psychiatric services they
15 maintain an office in Yorkton with three physicians. Those
16 practising actively in the hospital, I think, are sixteen.

17 COMMISSIONER VAN WART: What would be your
18 feeling if an out-patient diagnostic service was intro-
19 duced? Would there be a large increase in the number of
20 patients investigated?

21 DR. NOVAK: Initially, yes, and finally,
22 too, there would be an increase, but in the early stages
23 I think everyone would want to be investigated, just the
24 same as happened when the supplementary allowance came
25 into Saskatchewan giving our old age pensioners free
26 hospital care and medical care. There was an influx of
27 patients into all doctors' offices for a year or so, but
28 then it levelled out and it is not too bad, and I think the
29 same thing would happen if there were free diagnostic
30 facilities. There would be a greater demand initially,
and finally there would be more demand than there is now,
but certainly not at the same cost, in my opinion, as
as occupying a \$20.00 bed. I don't think people will abuse



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3 that service. I can't visualize a person wanting to have
4 a barium enema every month for x-ray purposes.

5 COMMISSIONER VAN WART: Would it be a fair
6 statement that the saving you pointed out to us would be
7 used up in extra services?

8 DR. NOVAK: I don't understand your question.

9 COMMISSIONER VAN WART: Well, the cost
10 to the government, you pointed out, would be \$20.00 as
11 compared to \$4.00 or \$5.00 if it were done on an out-
12 patient plan?

12 DR. NOVAK: Yes.

13 COMMISSIONER VAN WART: Would that \$15.00
14 be used up in extra services in the introduction of an
15 out-patient plan?

16 DR. NOVAK: I don't think anyone can answer
17 that question at the present time. We must bear in mind
18 these acute beds cost \$15,000.00 each, so that that
19 \$15,000.00 could be diverted towards the diagnostic care.

20 THE CHAIRMAN: You mentioned this gap
21 between the acute bed hospital -- involving long staying
22 cases. Have you any thought to put forward as to how that
23 gap might be bridged?

24 DR. NOVAK: Yes. The so-called beds for
25 the chronically ill -- I have seen senior citizens homes
26 and nursing facilities provided which eliminates the
27 necessity of admitting that patient into an acute hospital,
28 and possibly provision of a certain amount of nursing
29 facilities in the senior citizens home, coupled with
30 medical care when required -- it would be a sort of an
intermediate thing, if you like, if you don't wish to
build a convalescent home -- but I recall seeing one home

that service. I can't visualize a person waiting to have
a barium enema every month for x-ray purposes.
COMMISSIONER VAN WART: Would it be a fair
statement that the saving you pointed out to us would be
used up in extra services?

COMMISSIONER VAN WART: Well, the cost
to the government, you pointed out, would be \$10.00 as
compared to \$4.00 or \$5.00 if it were done on an out-
patient basis?

COMMISSIONER VAN WART: Would that \$10.00
be used up in extra services in the institution of an
out-patient basis?

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DR. WOVIN: Yes, the so-called beds for
the chronically ill -- I have seen senior citizens homes
and nursing facilities provided which eliminate the
necessity of admitting that patient into an acute hospital
and possibly provision of a certain amount of nursing
facilities in the senior citizens home, coupled with
medical care when required -- it would be a sort of an
intermediate thing, if you like, if you don't wish to
build a convalescent home -- but I recall seeing one home



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I think it was in Kansas City, where they have in this senior citizens' home nursing care, a regular visit by a physician when required, dental service and so on. I think that could be provided in a senior citizens' home at a less cost than building an acute bed.

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COMMISSIONER BALTZAN: May we ask you at a later date to submit your opinions and experiences in relation to the problem of needs versus the demand?

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DR. NOVAK: For what?

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COMMISSIONER BALTZAN: Services in the hospital as against outside -- the patient demand, the community demand, and the known needs. You also touched on that when you referred to your two cases: That was a question more of demand than actual need from the medical standpoint?

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DR. NOVAK: Demand for a bed, you mean?

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COMMISSIONER BALTZAN: Yes.

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DR. NOVAK: Yes.

COMMISSIONER STRACHAN: Referring to the Chairman's question, I could not see where a nursing service in the senior citizens' home would prevent patients from going to the acute hospital.

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DR. NOVAK: It would not prevent them if it was required but once they become convalescent they return.

COMMISSIONER STRACHAN: Would it solve that?

THE CHAIRMAN: The doctor is suggesting it is a stop gap approach in the meantime before we build the other type of hostel that has been suggested.

COMMISSIONER STRACHAN: I am thinking of the patient who has been in the acute hospital, would they



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take them back into that hospital ward?

DR. NOVAK: I do not think anything like that exists in Saskatchewan. It is just a suggestion.

THE CHAIRMAN: We can merely ask your opinion, we cannot very well start arguing with you after you give it. And now, there is one more phase here after the administrative arrangements for the discharge of patients when they become ready to be discharged, I mean, ready medically.

DR. NOVAK: Which patients do you refer to?

THE CHAIRMAN: Well, all patients in the hospital in the acute section.

DR. NOVAK: Of course, in all cases ---

THE CHAIRMAN: Well, Doctor, have you got a committee that deals with that or how is it dealt with? We know there is a 30-day situation when a report must be made to the Hospital Services Planning Commission.

DR. NOVAK: That is correct. I did not bring the list along but we have a number of long stay cases and these long stay cases are periodically reviewed by the medical staff.

THE CHAIRMAN: Apart from those, the short stay cases, the average cases, the day to day and week to week you have it appears to be a very good rate here of 8.42. I was wondering just how you arrive at that because it is below the average.

DR. NOVAK: Nine is the recognized figure, I believe?

THE CHAIRMAN: Yes.

DR. NOVAK: Well, that happens to be ---

THE CHAIRMAN: I was wondering if there was



take them back into that hospital ward?

that exists in Saskatchewan. It is just a suggestion.

THE CHAIRMAN: We can merely ask your

opinion, we cannot very well start arguing with you after

you give it. And now, there is one more phase here after

the administrative arrangements for the discharge of

patients when they become ready to be discharged, I mean,

very briefly.

DR. NOVAK: Which patients do you refer to?

THE CHAIRMAN: Well, all patients in the

DR. NOVAK: Of course, in all cases --

THE CHAIRMAN: Well, Doctor, have you got

a committee that deals with that or now is it dealt with

a. Now there is a delay situation when a patient has to

move to the hospital before the Committee

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it is below the average.

DR. NOVAK: There is the recognized figure.

I believe?

DR. NOVAK: Well, what happens to the

THE CHAIRMAN: I was wondering if there was



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3 anything special by which you had been below the average
4 figure.

5 DR. NOVAK: Those two cases I quoted
6 reduced the average stay, they only stayed four days.

7 THE CHAIRMAN: That is a pretty high price
8 to pay.

9 DR. NOVAK: I am afraid I cannot say, it
10 rests with the physician.

11 THE CHAIRMAN: Do you nudge the physician
12 at all?

13 DR. NOVAK: Only in having these cases
14 reviewed. You must bear in mind that all hospital
15 administrators are not physicians and possibly could not
16 express the same opinion as I am expressing here. Perhaps
17 I should not have expressed some of these that I have
18 expressed.

19 THE CHAIRMAN: Well, Dr. Novak, we are
20 very grateful to you for having accepted our invitation
21 to consider the questions that we submitted. Thank you
22 for the assistance you have given us.

23 The next brief is that of the Saskatchewan
24 Teachers' Federation and this will be Exhibit 109.

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---EXHIBIT NO. 109: Submission of Saskatchewan
Teachers' Federation.

anything special by which you had seen below the average

OK, NOWAY: Those two cases I noted
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administrators are not physicians and possibly could not
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very grateful to you for having accepted our invitation
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for the assistance you have given us.

The next trial is that of the chairman.
The next trial is that of the chairman.

---EXHIBIT A---
Admission of Evidence



SUBMISSION OF
SASKATCHEWAN TEACHERS' FEDERATION

APPEARANCES: Mr. W. A. HERLE

Mr. C. D. Lamer

MR. HERLE: Mr. Chairman, we had hoped to have more of our executives present today but as it is a school day and they are supposedly working we cannot do this.

We, first of all, would like to thank you for the kind invitation that you have given us to present a brief at this time. I should first of all state as a federation we represent 9,000 teachers in Saskatchewan composed of the public school and collegiate teachers in the province. The major, or one of the major tasks is to provide the very best possible instructional facilities and to do this we have to have the proper physical, emotional and mental health of students and at times in may even be a decisive factor in their progress.

As far as presenting this presentation I am at your disposal. My intention was to read the summary under conclusions.

THE CHAIRMAN: Very well.

MR. HERLE:

1. The pre-school and school period of the lives of people provide the best periods in which preventive medicine programs may be commenced.
2. If the program carried out during these periods results in generations of healthy, virile people as they move into adulthood, a most important goal of



Mr. W. A. Clark

APPROPRIATE

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 a school day and they are apparently working we cannot
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 for the kind invitation that you have given us to present
 a brief at this time. I should first of all state as a
 federation we represent 9,000 teachers in 34 states
 composed of the public school and collegiate teachers in
 the province. The nation, on one of the major tasks is
 to provide the very best possible educational facilities
 and to do this we have to have the proper physical,
 emotional and mental health of students and at times in
 any even as a decisive factor in their progress.

As far as presenting this presentation I
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 summary under consideration.

THE CHAIRMAN: Very well

MR. CLARK:

The first school and school period of the lives of
 people provide the best periods in which preventive
 medicine programs may be initiated.

4. If the program started out during these periods
 results in generations of healthy, virile people as
 they move into adulthood, a most important goal of



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our society will have been met.

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3. Such a program should give attention to the medical, dental and emotional needs of all pre-school children and school students.

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4. Pre-school clinics should be held in such numbers and places that all pre-school children should have periodic examinations. Follow-up treatment should be assured for all who require it.

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5. Every child should be given a physical check-up when he enrolls for school. Any defects should be corrected.

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I was most interested in noting in the presentation of the College of Physicians and Surgeons they apparently stress this point, if the brief was reported correctly, that one of the things they apparently recommended was that all students should have a visual and hearing test not later than grade 3. I think that is one of the things mentioned.

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6. Periodic medical and dental examinations should be given throughout the students' school life.

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7. These suggestions will require a considerably improved program than that being carried on at the present time. Some requirements are:

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(a) public health nurses in sufficient numbers to assist doctors in holding the necessary number of clinics for pre-school children.

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(b) school nurses in sufficient numbers to examine every child in the schools at least annually and to deal with all particular cases referred to them by teachers;

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(c) an arrangement under medical care plans which will assure immediate treatment of any

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3. Such a program should give attention to the medical, dental and nutritional needs of all one-school children and school districts.
4. Two-school districts should be held in such respects and places that all one-school and two-school districts have periodic examinations. Follow-up treatment should be secured for all who require it.
5. Every child should be given a physical examination when he enters for the first time. All records should be maintained in the health department.
6. The health department should be responsible for the presentation of the children of the health department and their regularly scheduled visits to the point of the first examination. The health department should be responsible for the children of the health department who are reported seriously ill or who are in the hospital. The health department should be responsible for the children of the health department who are reported seriously ill or who are in the hospital. The health department should be responsible for the children of the health department who are reported seriously ill or who are in the hospital.
7. There are suggestions that the health department should be responsible for the children of the health department who are reported seriously ill or who are in the hospital. The health department should be responsible for the children of the health department who are reported seriously ill or who are in the hospital. The health department should be responsible for the children of the health department who are reported seriously ill or who are in the hospital.
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3 diagnosed ailment;

4 Before I go any further I should mention
5 that we have no definite policy about what kind of medical
6 care plan we should have.

7 THE CHAIRMAN: But you are concerned that
8 there should be a service available?

9 MR. HERLE: Yes.

10 (d) provision for treatment for correction of hear-
11 ing or sight defects.

12 8. A complete and continuous program of vaccination and
13 inoculation for all communicable diseases that can
14 thereby be treated should continue high on the
15 list of priorities in a health program and should
16 be commenced early in the lives of Canadians.

17 9. In addition to the purely physical needs of children
18 a complete program leading to the early identifica-
19 tion of emotional problems and their correction
20 should be carried out. This would require that:

- 21 (a) educational psychologists should be employed
22 in such numbers that they can reasonably deal
23 with the children referred to them by teachers;
24 (b) educational psychologists should be employed
25 in sufficient numbers to offer this service
26 to all schools even in the remotest areas of
27 our country.

28 I might mention we have a few educational
29 psychologists in Saskatchewan. I believe in the health
30 regions we have six and the costs for these are being
shared by the Federal and Provincial governments; if my
information is correct the Federal Government at the
moment pays two-thirds of the costs of these educational



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3 psychologists and the Province pays one-third.

4 ~~THE~~ THE CHAIRMAN: When you say employed, by
5 whom?

6 MR. HERLE: These are being employed by
7 the health region at the moment and in the City of
8 Regina we have two and they are employed by the City
9 Health Department and by the School Board.

10 THE CHAIRMAN: You are not suggesting
11 employment by school boards?

12 MR. HEARLEY: No, we have not suggested it.

13 MR. EAMER: We do not care who pays for it
14 as long as we have it.

15 MR. HEARLEY:

16 10. Physical education programs provide activities for
17 students that improve their general health and
18 develop their physiques. These physical attributes
19 lay the basis for a sustained healthful and happy
20 adulthood. To this end there should be provided:

21 (a) adequate gymnasium space and equipment in
22 all schools;

23 (b) an adequate supply of teachers, well trained
24 in physical education, to carry out the
25 requirements of the best possible physical
26 education program.

27 11. All Canadian children should be assured a healthful,
28 adequate and well-balanced diet. Pre-school clinics
29 will detect evidence of malnutrition at the early
30 ages. Provision must be made to remedy any harmful
home situation causing the infirmities of mal-
nutrition. When teachers and school nurses detect
such evidence among school age children and adolescents



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THE CHAIRMAN: When you say employed, by whom?

Whom?

MR. HARRIS: There are being employed by

the health region at the moment and in the City of Regina we have two and they are employed by the City Health Department and by the School Board.

THE CHAIRMAN: You are not suggesting

employment by school boards?

MR. HARRIS: No, we have not suggested it.

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10. Physical education programs provide activities for students that improve their general health and develop their physiques. These physical attributes lay the basis for a sustained mental and happy outlook to life and there should be provision for adequate physical space and equipment in

(1) an adequate supply of teachers, well trained in physical education, to carry out the requirements of the best possible physical

adequate and well-balanced diet. The school clinics will detect evidence of malnutrition at the early stage and cause the attention of the parents to be directed to the situation causing the malnutrition of their children. When teachers and school nurses detect such evidence among school and adolescent



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4 there should be some provision for necessary
5 supplementary diets and vitamin rich foods. This
6 may require school-supplied noon lunches in some
7 instances.

8 12. The recreational aspect of physical education pro-
9 grams should be emphasized. Canadian children
10 everywhere live close enough to our innumerable
11 natural beauty spots that they should be encouraged
12 to appreciate and enjoy the flora and fauna of our
13 country. To make this possible in our gradually
14 expanding urban society the possibility of organized
15 youth camps and camp programs should be explored.
16 Organizations responsible for establishing and
17 operating these should be encouraged and supported.

18 In summation we wish to emphasize again that
19 we believe the early and developmental years of our people
20 are the most important in the preventive aspects of any
21 Canadian health services plan. We believe that a
22 complete and comprehensive program should be developed
23 and carried out which will provide through pre-school
24 clinics and school services the best preventive health
25 and psychological services that are possible today.

26 We have not dealt with the cost of such a
27 program. We are sure that it will be considerable and
28 will require the financial assistance of the Federal
29 Government.

30 We offer to all governments, local, pro-
vincial and federal, the co-operation of our organization
in any plan which will promote the best possible health
program for Canadians.

THE CHAIRMAN: Thank you Mr. Herle. We



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4 are anxious that the Teachers' Federation should make
5 known its views. We recognize the fact that the teachers
6 in the primary and secondary schools are so intimately
7 in touch with the children and the health needs of the
8 children and the province and we are grateful to the
9 association for having accepted our invitation.

10 Now, Miss Girard, do you have any questions?

11 COMMISSIONER GIRARD: Mr. Herle, on page
12 4 you say:

13 "At the present time there are no school
14 "nurses, as such, employed by any government,
15 "local or provincial, for work in
16 "Saskatchewan schools outside of cities."

17 Then you refer to the public health nurses as doing the
18 school work. Would you suggest or would you prefer to
19 see school nurses as such employed by school boards or
20 municipalities or public health nurses employed in public
21 health nursing departments? What you refer to here,
22 public health nurses as doing school work, it is generally
23 the policy across Canada. There are some places where
24 school nurses are employed by the school board or the
25 municipality but have you a preference here or is it just
26 a lack of facilities or not enough of them?

27 MR. HERLE: Well, there are, of course,
28 two points of view; first of all, if the principal is
29 supposed to be in charge of the programme of the school
30 and if some of our schools are large enough -- say in the
event you need a full time health nurse, there is a
possibility of a complication of interest. For instance,
we have some schools which are approaching one thousand
students and these virtually require a part time health



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You say:

"At the present time there are no school nurses, as such, employed by any government, local or provincial, for work in educational schools outside of cities."

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Two points of view; first of all, if the principal is supposed to be in charge of the programme of the school and if some of our schools are large enough -- say in the event you need a full time health nurse, there is a possibility of a complication of interest. For instance, we have some schools which are approaching one thousand students and these virtually need a part time health



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4 nurse at the present time. This is one point of view
5 that we have but, again, I think our major concern is
6 that there be enough care at the moment and no serious
7 problem has arisen.

8 MR. EAMER: I would think we would prefer
9 the schools to employ the nurse. The public health
10 schools have a lot of other activities as well as inspec-
11 tions in schools and we feel again that dealing with
12 children they require a special type of training. We
13 would prefer to see school nurses as such rather than
14 health nurses.

15 COMMISSIONER GIRARD: You are now aware
16 of the fact that in large cities public health nurses do
17 have a school population, they look after the school
18 population, 900 or 1000 and still have other activities
19 such as well baby clinics and so on and do the fill up
20 work from the school also. I know it would be preferable
21 if every school had its own nurse but it is not a
22 unique situation, you realize that this is being done
23 generally.

24 MR. EAMER: We are not particularly concerned
25 with the cities where these services are quite good, but
26 we are concerned with the rural areas which make up most
27 of the province of Saskatchewan where facilities are not
28 as competent as they are in the cities.

29 COMMISSIONER GIRARD: In your rural areas,
30 how often would the public health nurse or the health
unit nurse, how often would she visit the school?

MR. EAMER: This varies a great deal over
the province. We tried to get some specific information
on this, we found a great variety. In the well organized



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COMMUNICABLE DISEASES: You are now aware

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have a school population, they look after the school
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on this, we found a great variety. In the well organized



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3 health unit of Swift Current there is generally annual
4 inspection. We found in other parts of the province they
5 had not had a school nurse in five years.

6 COMMISSIONER GIRARD: I understand your
7 worry about more nurses. In number 5 on page 5 you say:

8 "School nurses in sufficient numbers to
9 "examine every child in the schools at
10 "least annually ---".

11 Do you mean here an annual physical examination done by
12 the nurse only or do you refer to the annual physical
13 done by the doctor with the nurse?

14 MR. HEARLEY: I think we realize that at
15 the present time at least it would be impractical for
16 a doctor to examine each child each year. We do advocate
17 that at several times throughout the child's career he
18 receive an examination by a doctor. How often this
19 should be or when would be the proper time is not for us
20 to say, it is for you to say. Some of our members have
21 suggested at the beginning and perhaps before they enter
22 high school but you realize if there is a question of
23 choice involved it is for the medical profession to
24 decide, not for us. We do not want to enter their
25 particular field.

26 COMMISSIONER GIRARD: I was wondering if
27 you were advocating that this annual examination would
28 be done by the nurse? You understand that they would
29 be limited because the nurse is a nurse and not a doctor
30 and there are certain things that a nurse can find and do
something about and there are certain others that she
cannot.

MR. HERLE: Provided that each child had



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3 regular medical check-ups by a doctor. Even starting
4 with a programme at the age of five or six would help
5 a great deal if they had a competent medical physician.

6 COMMISSIONER GIRARD: At least an entrance
7 one and one leaving school as a minimum?

8 MR. HERLE: Yes.

9 THE CHAIRMAN: Mr. Hearley, in the summary,
10 numbers 3 and 4, with this programme of pre-school and
11 school examinations, what authority should arrange for
12 those examinations, particularly the pre-school one?

13 MR. HERLE: Having lived in the Swift
14 Current area perhaps I might say a word about what happens
15 there.

16 Having worked on the Swift Current Health
17 Region for many years before I moved to Regina, at one
18 time the Swift Current Health Region, all children up to
19 16 years of age were entitled to free dental services.
20 At the moment I think it is down to 12 in recent years.
21 Whether or not the child got the free dental care was
22 determined by the parent of course, but on occasion a
23 dentist would set up a service in a community for a
24 certain period of time, and stay there until their work
25 was completed, so in this case it was under the authority
26 of the Swift Current Health Region. We feel it should be
27 set up, but we are not at the moment going to decide how
28 it should be set up. Our point is that it should be set
29 up.

30 THE CHAIRMAN: What about the physical
check-up that you suggest when the child enrolls in
school? At the age of six, I take it that is what you
mean?



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4 MR. EAMER: Yes, we feel this should be a
5 requirement before they are admitted.

6 THE CHAIRMAN: The child would bring a
7 certificate or something?

8 MR. EAMER: Yes, this happens when you send
9 your child to camp. You must produce a certificate that
10 they are in a condition to go to that camp.

11 THE CHAIRMAN: You are not suggesting that
12 it should be done by the school authority?

13 MR. EAMER: It could be.

14 THE CHAIRMAN: You say it is relatively
15 simple in the urban centres, but in the rural areas does
16 the fact that the whole Province is now under the larger
17 unit of administration appear to you to make possible
18 provision of such an examination?

19 MR. EAMER: Yes it does.

20 THE CHAIRMAN: Under the unit board?

21 MR. EAMER: Under the unit board, who could
22 establish the necessary clinics, if that is the way it
23 should be done.

24 MR. HERLE: This is done to a lesser
25 extent again in the Swift Current Health Region, but only
26 by nurses. All pre-school children came in some time in
27 May to be examined fully by a nurse, but it has not
28 got to the next step, to be examined by a doctor, but
29 there has been some work done in this field.

30 MR. EAMER: We mentioned in the brief
Mrs. Rawson, who is working with us.

THE CHAIRMAN: Yes, I was just going to
discuss that, so will you proceed?

MR. EAMER: She maintains about ten per cent

MR. EMMETT: Yes, we feel this should be a

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unit of administration apart from you to make possible

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THE CHAIRMAN: Would this unit be the

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4 of the students have reading difficulties, and we are
5 not talking now about below normal intelligence, but
6 average or better intelligence, yes, ten per cent fail to
7 read effectively and efficiently simply because of
8 emotional blocks. These are some of the things which we
9 think should be discovered earlier, and we don't feel that
10 at the present time there is enough taking place in
11 this field to discover perhaps in pre-school and grades
12 1, 2 and 3 particularly of the Province.

13 THE CHAIRMAN: You are talking of something
14 now besides physical handicap such as a deficiency in
15 hearing or sight?

16 MR. EAMER: Yes, this is another serious
17 problem in our schools.

18 THE CHAIRMAN: Did the Federation partici-
19 pate in that pilot project in the Humboldt-Wadena area
20 a year ago?

21 MR. EAMER: Yes we did.

22 THE CHAIRMAN: I am a little bit out of
23 touch. Is it being continued this year as a follow-up?

24 MR. EAMER: I couldn't tell you that.

25 THE CHAIRMAN: This situation found by
26 Mrs. Rawson now, have you any suggestions to make as to
27 how it might be developed on a much wider basis than one
28 province has been able to do?

29 MR. EAMER: I think a lot of trouble is
30 the problem of detection and recognition and Mrs. Rawson
is mainly working with groups of teachers in making
them aware how to detect. She is also giving them some
methods of counteracting, but her main work is in the
field of teaching teachers to recognize the problem.



of the students have reading difficulties, and we are not talking now about below normal intelligence, but average or better intelligence, yes, ten per cent fail to read effectively and efficiently simply because of emotional blocks. These are some of the things which we think should be discovered earlier, and we don't feel that at the present time there is enough taking place in this field to discover perhaps in pre-school and grades 1, 2 and 3 particularly of the province.

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MR. BAKER: Yes, this is another serious problem in our schools.

rate in that area project in the two-to-three-year period in 1960?

MR. BAKER: Yes we did.

THE CHAIRMAN: I am a little bit out of touch. Is it being continued this year as a follow-up?

MR. BAKER: I couldn't tell you that.

THE CHAIRMAN: The statement found by Mrs. Jackson that, have you any suggestions to make as to how it might be developed on a much wider basis than the province has been able to do?

MR. BAKER: I think a lot of trouble is

the problem of detection and recognition and that Jackson is mainly working with groups of teachers in making them aware now to detect. She is also giving them some methods of counteracting, but her main work is in the field of teaching teachers to recognize the problem.



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4 THE CHAIRMAN: Have you any other observa-
5 tions that you would like to make, Mr. Herle or Mr.
6 Eamer?

7 MR. EAMER: I just have one in connection
8 with the physical education facilities that the Depart-
9 ment of Health and Welfare have shown a concern about
10 physical education and physical condition of the people
11 of the country recently in the establishment I think of
12 a fund of five million dollars or something to try to
13 improve it, and I am submitting that perhaps this is a
14 good place to start, is in the schools, and that we in
15 this Province, I cannot speak for others, do suffer from
16 a lack of physical education facilities. Then again,
17 not so much in our cities as in our rural areas, and that
18 actually we do have a wide participation in the games,
19 but people tell me in the physical education field that
20 perhaps the least effective form of activity for develop-
21 ment of physique and so on are competitive games which
22 we mostly are interested in, that actually for the real
23 development of physique and physical education, that
24 facilities are practically non-existent, and I think that
25 perhaps in this field more should be done to encourage
26 development in all areas.

27 I am rather interested, in England in
28 schools that have 250 children or more the Ministry
29 requirement is that that school must have an auditorium
30 and a gymnasium.

As the Government has seen fit to make a
grant for physical education, both for facilities and
the development of programmes, I would suggest to you
that this could be explored.



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2
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4 MR. HERLE: This matter of providing
5 money for occasional education, I believe the Federal
6 Government provides up to 40% for facilities, not for
7 the building itself. There are grants also made if
8 provinces contribute to the plan and are engaged in it
9 themselves to help train teachers for the occasional
10 education programme, and since this precedent has been
11 established, and the health of the people is of the
12 utmost importance, not only for the people, but for society
13 itself, a look should be taken at the cost in this
14 particular field, namely the grants for buildings and
15 training teachers, despite constitutional concerns.

16 THE CHAIRMAN: I suppose the constitutional
17 concerns can be overcome by demanding provincial co-
18 operation and by continuation of the grant or the condi-
19 tional grant system?

20 MR. HERLE: Yes.

21 THE CHAIRMAN: Thank you very much gentlemen.
22 We are glad to have your views, and we are indebted to
23 you for them.

24 We will take a short recess and then continue
25 with the Saskatchewan Hospital Association.

26 ---A short recess.

27 ---EXHIBIT NO. 110: Submission of the
28 Saskatchewan Hospital
29 Association.

30 ---EXHIBIT NO. 110A: Submission to the Advisory
Planning Committee on
Medical Care by Saskatchewan
Hospital Association.



194, 1945: This pattern of providing

money for educational education, I believe the Federal Government provides up to 50% for facilities, but for

the building itself. There are grants made to

provinces contribute to the plan and are engaged in it

themselves to help train teachers for the educational

education programme, and since this process has been

established, and the health of the people is of the

utmost importance, not only for the people, but for society

itself, a look should be taken at the state in this

particular field, namely the plan for training and

training teachers, to see how consistent it is with

the plan. I suggest that a committee

concerns can be set up by the government and local co-

operation and by contribution of the government and the local

central government

THE STATE. I think you very much interested

we are glad to hear your views, and we are interested to

you for them.

We will have a short meeting and then

with the Government and the local Association.

---A short meeting

Committee of the
Government and the local Association

---A short meeting

Submitted to the Government
Planning Committee on
Technical Education
1945

---A short meeting



SUBMISSION OF

THE SASKATCHEWAN HOSPITAL ASSOCIATION

APPEARANCES: Dr. A. L. Swanson
Mr. H. H. Bassett
Mr. J. D. McMillan
Mr. A. R. Thorfinnson

DR. SWANSON: Mr. Chairman, lady and gentlemen, on behalf of the Saskatchewan Hospital Association I would like to present my colleagues. Mr. Herbert Bassett, the Past President of our Association from Prince Albert. Mr. McMillan, our Executive Director, and Mr. Thorfinnson, our Assistant Director.

I had the pleasure of meeting you and renewing acquaintances with many of you yesterday. I would like to say that the Association had not intended to present a brief to the Commission, owing to the fact that we had presented a complete brief to the Thompson Committee last year, and this brief has formed one of the major sources of information for the brief of the Canadian Hospital Association, and we had intended that we, along with all other hospital associations in Canada, be represented that way. However, Mr. Chairman, we were extremely pleased to receive your letter of invitation to come and answer certain questions in particular, and this we have done.

We have provided you with copies of the original brief, plus the summary which was used in the presentation which has a little additional data in it, and on these notes which you have here. We have attempted



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4 to answer the questions specifically, by referring to
5 the brief and perhaps adding a few points.

6 I should add that Don A. MacMillan, our
7 President, asks me to pass his apologies to you for being
8 unable to attend this hearing.

9 THE CHAIRMAN: You are the Past President?

10 DR. SWANSON: I am sir. We have taken,
11 Mr. Chairman, your letter and answered the questions
12 starting right in the first paragraph, with the first
13 question you asked, and this covers in part several of
14 the others, concerns utilization of hospital facilities
15 in Saskatchewan, and in this we would refer you in our
16 notes to pages 13 and 17 of our brief. The rate of
17 utilization has remained in this Province over 200
18 admissions per 1,000 beneficiaries per year. We stated
19 previously there didn't appear to be an easy solution
20 until there was a very considerable change in the thinking
21 of the general public, physicians, hospital trustees and
22 administrators as to the essential nature and purpose of
23 the general hospitals. I should say, Mr. Chairman, that
24 we believe that there has been a considerable change in
25 the thinking during this past year in this Province owing
26 to the activities of the Advisory Planning Committee and
27 the activities in connection with medical care proposals
28 for this Province, so that there has been, in our opinion,
29 a considerable change since this first brief was pre-
30 sented. However, as you will note on these pages, 13 to
17, we refer to the need for several features that do not
now exist in our hospital plan. Out-patient coverage,
development of rehabilitation facilities, development of
convalescent care facilities, development of home care



to answer the question specifically, by referring to
the brief and perhaps adding a few points.

I should add that Hon. A. Macdonald, our

President, asked me to pass his apologies to you for being
unable to attend this session.

The Chairman, you are the first President

of the Association, I am glad to have you here.

Mr. Chairman, your letter and answered the question

standing right in the first paragraph, with the fact

question you asked, and this covers it, but as most of

the course, complete utilization of hospital facilities

in Saskatchewan, and in this we would refer you in our

notes in paper 10, and 11 of our brief. The point of

reference on the subject in this program is on the

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the thinking during this past year in this respect with

to the activities of the Advisory Planning Committee and

one hospital in connection with medical and business

for this Province, so that there has been, in our opinion,

a considerable change since the first paper on the

subject. However, as one of 1 point, these papers, 10 to

17, we refer to and need not repeat. It is that to

now exist in the hospital, and the hospital, and the

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development of these



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4 programmes, and of course, as is mentioned frequently,
5 the need for provision of various types of chronic care.

6 In short, Mr. Chairman, in reply to your
7 first question, the utilization of hospital facilities,
8 we feel that there is a considerable amount of poor
9 utilization owing to the lack of certain types of facilities,
10 which we specify in our previous brief.

11 Your second question is really related to
12 the first, the relative need for active, convalescent
13 and chronic beds, and rehabilitation facilities, and we
14 would call your attention particularly to page 16 of this
15 original brief, in which the Saskatchewan Hospital
16 Association is calling primarily for provision of
17 ancillary beds to general hospitals, for example chronic,
18 convalescent, rehabilitation beds, geriatric beds,
19 psychiatric beds.

20 THE CHAIRMAN: Is that as wings addended
21 to the present buildings, or?

22 DR. SWANSON: Either as wings, or separate
23 buildings, or wards therein, or perhaps located immediately
24 adjacent to the general hospital. I think the circumstances
25 might vary, sir, in dictating exactly the form it would
26 take.

27 We believe that relocation of a good many
28 general hospital beds is necessary in our Province.
29 There is the need for certain rebuilding and renovation
30 in certain areas and there may be a need for addition to
bed complement to some small degree. However, in this
Province as a whole, additional general hospital beds
do not seem to be needed until there is a significant
increase in population. If ancillary care facilities



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3 are provided there may be no need for overall addition
4 of general hospital beds. Again, as the population grows,
5 there may be need for additional active or acute beds.

6 THE CHAIRMAN: There has been considerable
7 redistribution of population in the Province. That has
8 created some problem no doubt?

9 DR. SWANSON: Yes, the rural/urban shift,
10 so-called, Mr. Chairman, which has been very marked in
11 Saskatchewan, where particularly the three or four
12 largest cities have grown quite rapidly, whereas the
13 population as a whole has grown much less.

14 THE CHAIRMAN: About 9% in the ten-year
15 period?

16 DR. SWANSON: Yes. The third question in
17 your letter concerned the length of stay of patients and
18 the length of stay of patients in our brief at page 17,
19 we say has fallen somewhat over a ten-year period, and
20 this appears to be remaining relatively constant at
21 around ten days, or slightly under.

22 COMMISSIONER BALTZAN: For the Province?

23 DR. SWANSON: Yes. Here again we refer
24 back to the same point again, the need for certain
25 ancillary types of facilities, and accommodation, and
26 personnel.

27 THE CHAIRMAN: That is the matter that was
28 referred to both by the Minister this morning and Dr.
29 Novak as the gap in the accommodation?

30 DR. SWANSON: That is correct sir. In this
previous brief we also mentioned other items and the
length of stay. We believe in a programme that is free,
in quotes, maybe -- that is, the convenience of the patient



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4 may become a factor. If there is a bus connection
5 tomorrow they may stay another day. This may occur with
6 the physician as well. They find it more convenient to
7 discharge, or certainly have no urgency pressed upon them
8 to discharge a patient.
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1 Another factor that we believe is operative is the increas-
2 ed complexity of treatment. In short, we had hoped that
3 the average day's stay might fall more, but there are a
4 variety of factors which appear to be acting to hold it
5 about constant.

6 THE CHAIRMAN: Before you leave that,
7 Dr. Swenson, there was a reference to home care, home care
8 programs, in your Brief on page 18?

9 DR. SWANSON: Yes.

10 THE CHAIRMAN: Is there any help you
11 can give us, because I understand you are operating a
12 limited home care program?

13 DR. SWANSON: We have operated a limi-
14 ted program for just about two years.

15 THE CHAIRMAN: Can you tell us whether
16 it is related to this length of stay -- if there is any
17 implication?

18 DR. SWANSON: Yes, sir. We have re-
19 duced our length of stay in the rehabilitation ward as well.
20 Actually, we have gone a little further than home care in
21 many other areas and have placed patients on this program
22 who might be considered as being under active treatment,
23 and we have been able to treat these patients with reason-
24 able success. Approximately two-thirds have been returned
25 to at least independence in their home. This has been done
26 at an average cost of about \$4.00 a day instead of \$20.00
27 or more a day by keeping them in the main hospital.

28 THE CHAIRMAN: From the experience do
29 you see -- and this would be more or less of a pilot pro-
30 ject?



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24 at an average cost of about \$4.00 a day instead of \$20.00
25 or more a day by keeping them in the main hospital.

26 THE CHAIRMAN: From the experience do
27 you see -- and this would be more or less of a pilot pro-



1 DR. SWENSON: Yes.

2 THE CHAIRMAN: ...as to whether it
3 should be developed further; because it appears to be hav-
4 ing very good results both from the rehabilitation stand-
5 point and finance-wise?

6 DR. SWANSON: Quite. I should emphasize,
7 Mr. Chairman, this type of care is better for the patient.
8 It is not just cheaper; it is much better when the patient
9 is properly chosen, and they do better than remaining in
10 hospital. It is a good deal less expensive. We based our
11 program on experience from many other centres, and I
12 should add we are now experimenting with home care for
13 psychiatric patients -- just beginning. We have almost no
14 funds, and it is a rather small show, but we are attempting
15 to experiment with home care in certain types of mental
16 illness.

17 THE CHAIRMAN: This money for the pilot
18 project came from the Government?

19 DR. SWANSON: Yes, sir.

20 THE CHAIRMAN: Was it Provincial and
21 Dominion?

22 DR. SWANSON: I believe this is true.
23 It certainly came from the Province, and I believe also
24 the Dominion.

25 THE CHAIRMAN: Dr. Novack seemed to
26 think it may not be possible to introduce such a program
27 in a community the size of Yorkton -- and, therefore, many
28 smaller communities in Saskatchewan: Have you any view to
29 express on that from your experience, or is this going to
30 be related more to the larger cities?



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be related more to the larger cities?



1 DR. SWANSON: I think here I can give
2 an answer to that: Two-thirds of our patients at the
3 University Hospital come from outside Saskatoon City and
4 district, so we are only working on one-third of a hospital
5 for a home care program, because this is done within the
6 city; it almost has to be. Yorkton Hospital would be, I
7 am sure, at least one-third as big as ours -- larger than
8 that -- and on this basis we have had success, and I be-
9 lieve they could too. There are other factors: You do
10 need to have some medical social service work available;
11 it is very important. You do have to have the home nursing
12 services available. We use the VON which provide us with
13 very excellent service. You have to have home-maker service,
14 but I believe this can be found in most places and, of
15 course, you need medical supervision overall. I believe,
16 without wishing to contradict Dr. Novack too strongly, that
17 Yorkton could operate a program.

18 THE CHAIRMAN: And perhaps ten more
19 cities in the Province?

20 DR. SWANSON: At least. There was even
21 a suggestion this can be done in a rural area provided the
22 rural patients are not at great distances from the hospital --
23 say, a radius of eight to ten miles. This is no greater in
24 travel time than a few blocks in a very large city. I
25 should say, to the best of my knowledge, there will be two
26 more home care programs commenced this year in Saskatchewan;
27 one is in Moose Jaw, and I cannot recall where the other
28 is.

29 COMMISSIONER McCUTCHEON: I take it the
30 patient is under no greater financial responsibility under



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an answer to that: Two-thirds of our patients at the

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one is in Moose Jaw, and I cannot recall where the other



1 the present home care program than if he had stayed in the
2 hospital?

3 DR. SWANSON: That is correct.

4 COMMISSIONER McCUTCHEON: This is an
5 extension of the in-hospital service?

6 DR. SWANSON: Yes.

7 COMMISSIONER McCUTCHEON: But in the
8 home, paid for in the same way?

9 DR. SWANSON: Yes. This is under a
10 grant system now. We would hope eventually it would become
11 part of the so-called hospital rate -- a recognized part of
12 providing hospital care. I should add it does not decrease
13 your hospital costs. It actually has the effect of adding
14 X dollars, but at a much lower rate, to your total hospital
15 expense.

16 THE CHAIRMAN: Are you able to give us
17 the approximate number of patients or individuals who have
18 been dealt with under this pilot project in the University
19 Hospital?

20 DR. SWANSON: I don't have that. I
21 know we have maintained an average of about twelve or so at
22 a time. The exact number I don't have.

23 THE CHAIRMAN: And the number of nurses
24 that involves -- say, VON?

25 DR. SWANSON: I can't give you the
26 actual number of VON nurses. We use one social worker and
27 one physiotherapist and one doctor supervising and solicit-
28 ing the general coordination of the program.

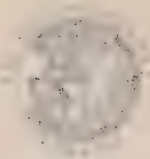
29 THE CHAIRMAN: Would he be full time,
30 or is this an additional duty he has in connection with his



1 hospital duties?

2 DR. SWANSON: This is his major activity,
3 but he does have some time for other hospital duties.

4 The next question, sir: Waiting periods
5 for admission: This is an extremely difficult one to
6 answer. We do not have any authoritative figures or surveys
7 which we have conducted. It is known there are relatively
8 long waiting periods in larger hospitals in the cities.
9 Conversely, in many of the small hospitals in the country-
10 side there is no waiting period at all, hardly ever, for
11 anybody. No matter how minor the condition, they can be
12 admitted forthwith. We do suggest in our notes that a
13 reasonable waiting period, or, a certain time of a waiting
14 period may be quite reasonable providing it does not affect
15 the emergency or very urgent type of case. There are
16 several reasons: If we wish to maintain an adequate range
17 of hospital facilities, these are extremely costly, and if
18 we maintain sufficient facilities in all hospitals to admit
19 any patient immediately, we would be greatly overstaffed,
20 over-bedded, over-equipped and so on, for most of the time.
21 This would be a great expense. Another reason a waiting
22 period for admission is found reasonable in a non-urgent
23 type of case, is that one of the first things the patient
24 asks the doctor -- if the doctor decides at this instant
25 that patient "X" should go into hospital for a certain
26 activity-- perhaps one of the first things the patient will
27 ask is, "I will have to arrange to get a housekeeper", or
28 arrange certain things in his business. This is not
29 necessarily, or certainly not always to the patient's
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1 some of the larger centres overly long. You have other
2 factors we have mentioned: It is not uncommon for patients
3 to appear on the waiting list of more than one hospital.
4 I don't have any personal knowledge of this, but they may
5 even approach two different doctors -- things like this
6 which exaggerate the problem. There are waiting lists in
7 the major hospitals, and these may be too long.

8 THE CHAIRMAN: There is no suggestion
9 any emergency cases are not taken care of?

10 DR. SWANSON: To the best of our know-
11 ledge, all emergencies or urgent cases are admitted. There
12 is no waiting period in the case of an urgent case -- perhaps
13 only a day or so.

14 I have been passed some information,
15 Mr. Chairman, very kindly concerning the number of V.O.N.
16 and so on utilized. I should say this is done on a service
17 basis, and as far as I am aware they don't set aside
18 specific nurses necessarily. Firstly, there were a total
19 of 136 patients in 1961 treated in the home care program.

20 THE CHAIRMAN: These are individuals?

21 DR. SWANSON: That is individuals; an
22 average of 12.3 a month, and there were 1,561 nursing
23 visits and 191 orderly visits. I can't convert this into
24 what this might mean in the number of V.O.N. nurses occupi-
25 ed full time. A total of eight V.O.N. nurses participated
26 in providing these visits.

27 THE CHAIRMAN: Thank you.

28 DR. SWANSON: The next question which
29 appears, sir, concerns the fact that certain beds may not
30 be used for various reasons, and here we have listed several



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15 that the emergency cases are handled very quickly.
16 I have been passed some information
17 that, and as far as I am aware they don't get worse
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19 of the patients in 1961 cases in the home care program.
20 THE CHAIRMAN: These are individuals?
21 DR. SWANSON: That is individuals; an
22 average of 100 a month, and there were 1,101 nursing
23 visits and 100 ordinary visits. I can't convert this into
24 what this might mean in the number of V.O.N. nurses occupied
25 full time. A total of eight V.O.N. nurses participated
26 in providing these visits.
27 THE CHAIRMAN: Thank you.
28 DR. SWANSON: The next question which
29 appears, and, concerning the fact that certain beds may not
30 be used for various reasons, and here we have listed several



1 factors that will tend to produce this. We have already
2 alluded to the fact many hospitals are located in small
3 towns; they are shrinking in size, and these hospitals not
4 infrequently will have quite a low occupancy, and this
5 harks back to the need for certain bed redistribution.

6 THE CHAIRMAN: We have been told there
7 is a survey being made at the present time?

8 DR. SWANSON: That is true, sir.

9 THE CHAIRMAN: Of hospital needs -- I
10 don't know what the name of it is -- and when the report is
11 available it is going to be furnished to us. The Minister
12 undertook to do that.

13 DR. SWANSON: That happens to be another
14 one of my hats; I sit on that committee. There is a
15 fluctuation which is pretty well beyond control in the
16 types of patients you may get. There may be a large number
17 of men who require medical treatment in a hospital, and
18 almost no women at that particular moment who require
19 obstetrical services, and in a small hospital this makes
20 a great difficulty because it is not flexible, and this
21 may affect large hospitals as well, where there may be
22 quite wide fluctuation for certain types of beds. Another
23 point, there are empty beds on the basis of recommended
24 occupancy. The figure that has been used for years is
25 eighty percent occupancy; that has been recommended. A
26 good many large hospitals operate on a much higher occupan-
27 cy. Eighty to eighty-five percent is recommended, and
28 these fifteen to twenty percent are not really unused. It
29 may be only one or two in some cases. I would refer to
30 these as turnover beds; that is, they are empty at that



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may be only one or two in some cases. I would refer to



1 moment, but patients have been booked into those beds to
2 arrive ~~the~~ afternoon or tomorrow morning. They are not
3 empty in the true sense. I would allude to seasonal ad-
4 missions: Harvest is a favorite one here -- the time of
5 planting or harvesting when people don't go to the hospital
6 if they can help it. Christmas is another pronounced ex-
7 ample where the occupancy of hospitals may drop down to
8 50% for a few days. Of course, the summer holiday period
9 does produce a certain decrease in occupancy -- not as
10 marked as the others. Staffing problems do occur, and this
11 varies all the way from the lack of a doctor in some small
12 communities -- the doctor leaves, or there is no doctor
13 in attendance, and the hospital may close temporarily --
14 to all other types of staff which may be lacking.

15 THE CHAIRMAN: I think it was in the
16 discussion with the Registered Nurses Association where
17 they were talking about shortage of nurses, and they told
18 us there were hospitals where a number of beds would be
19 closed during certain periods, and the holiday period, so
20 far as staff is concerned, and they mentioned the University
21 Hospital as one.

22 DR. SWANSON: That puts me on the
23 spot, doesn't it?

24 THE CHAIRMAN: No, not at all. It is
25 just a fact which ---

26 DR. SWANSON: I would hate to get into
27 any arguments with a nurse. I have learned from long ex-
28 perience it is better not to, but I would question there
29 is a shortage of nurses. As indicated in this Brief, there
30 is a very large increase in the number of nurses available



moment, but patients have been booked into those beds to arrive the afternoon or tomorrow morning. They are not empty in the true sense. I would allude to seasonal admissions: Harvest is a favorite one here -- the time of planting or harvesting when people don't go to the hospital if they can help it. Christmas is another pronounced example where the occupancy of hospitals may drop down to 50% for a few days. Of course, the summer holiday period does produce a certain decrease in occupancy -- not as marked as the others. Staffing problems do occur, and this varies all the way from the lack of a doctor in some small communities -- the doctor leaves, or there is no doctor in attendance, and the hospital may close temporarily -- to all other types of staff which may be lacking.

THE CHAIRMAN: I think it was in the discussion with the Registered Nurses Association where they were talking about shortage of nurses, and they told us there were hospitals where a number of beds would be closed during certain periods, and the holiday period, as far as staff is concerned, and they mentioned the University

DR. SWANSON: That puts me on the spot, doesn't it?

THE CHAIRMAN: No, not at all. It is just a fact which --

DR. SWANSON: I would have to get into any argument with a nurse. I have learned from long experience it is better not to, but I would question there is a shortage of nurses. As indicated in this Brief, there is a very large increase in the number of nurses available



1 per bed or patient now as opposed to ten years ago, not
2 only in Canada as a whole, but in this Province in parti-
3 cular, where our rate of increase in the number of personnel
4 available has been even more rapid than Canada as a whole.
5 I would refer to it as a relative shortage. Nurses them-
6 selves have been attempting to devise various ways and
7 means whereby you can conserve the services of a registered
8 nurse by the utilization of other personnel, and this is
9 done in many of our hospitals in this Province. I cannot
10 answer why there seems to be a shortage. We know in the
11 Summer-time --- and I suspect some of the reasons might
12 be that there appears to be a number of resignations.

13 THE CHAIRMAN: Before June?

14 DR. SWANSON: Before June, and also
15 during the Summer holiday season, and there is a great
16 tendency in the nursing population to travel -- to be
17 quite mobile -- and we certainly suspect that the nurse
18 who is single and has no family or responsibilities, and
19 free to travel -- although there have been many comments
20 made about payments of nurses, actually a young girl,
21 single and without responsibility, can do pretty well:
22 They can save up a thousand dollars in the course of a
23 year and take a trip to Hawaii, and many of them do. They
24 resign, take off for four months, and then come back.

25 I believe it was Dr. Bradley when he
26 was in Calgary who tried to make a survey of this and
27 showed a migration pattern of the nurses across the country
28 towards British Columbia, down to California and those
29 that were left, did not get married by that time, ended up
30 back in Canada. You wish some answer to why we closed the

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was in Calgary who tried to make a survey of this and
showed a migration pattern of the nurses across the country.

back in Canada. You wish some answer to why we closed the



1 100 beds at University Hospital?

2 THE CHAIRMAN: Oh no, I do not think
3 the Commission is concerned about the administration de-
4 tail and the operations of any one hospital. We are con-
5 cerned with matters of general application.

6 DR. SWANSON: I should say this was
7 due in part to a shortage of nurses on the nursing staff,
8 a shortage which we experience every Summer and which the
9 majority of our hospitals across the country experience
10 to a greater or lesser degree each Summer. It was rather
11 more acute this Summer than it had been previously and it
12 was also due to a shortage of other trained personnel.

13 THE CHAIRMAN: You accept it as an
14 isolated incidence. Is it in Provincial employment or
15 intra-Provincial?

16 DR. SWANSON: We do not believe so and
17 we are hopeful and quite confident this will not recur --
18 it may recur in five years or something like that. You
19 have some figures before you on the increase in numbers
20 of graduate nurses available. In 1948, the average of
21 graduate nurses -- a graduate nurse handled 4.2 patients
22 in this Province and those are registered nurses at work.
23 In 1958, there was only 2.4 patients per nurse showing the
24 increase in the number of nurses to patients and there
25 were more patients by that time almost approaching 100%,
26 so I regard it as a relative shortage.

27 The last question in your letter
28 referred to a reduction of daily census of provisional
29 alternative facilities. I believe we have referred to this
30 several times. Also we would like to draw to the attention



THE CHAIRMAN: I should say this is

due in part to a shortage of nurses on the nursing staff, a shortage which we experience every summer and which the majority of our hospitals across the country experience to a greater or lesser degree each summer. It was rather more acute this summer than it has been previously and it was also due to a shortage of other trained personnel.

THE CHAIRMAN: You speak of an

increased incidence. Is it in hospital employment or

in the community?

DR. SWANSON: We do not believe so and

we are hopeful and quite confident that will not occur --

it may occur in five years or something like that. You

have some figures before you of the increase in numbers

of graduate nurses available. In 1945, the average of

graduate nurses -- a graduate nurse handled 4.2 patients

in this Division and those are registered nurses at work.

In 1946, there was only 3.4 patients per nurse showing the

increase in the number of nurses to patients and there

were also assistants by that time almost approaching 100%

so I regard it as a relative shortage.

The last question in your letter

referred to a reduction of duty census of provincial

alternative facilities. I believe we have referred to this

several times. Also we would like to draw to the attention



1 of the Commission two other points that have been of
2 particular concern to the Saskatchewan Hospital Association
3 during recent months and these appear at the bottom of
4 page three and on page four in this short series of notes.
5 We thought the Commission might be interested in this.
6 It is the opinion of the Saskatchewan Hospital Association
7 that any plan which may be forthcoming -- I should say we
8 are in favour and on record as in favour of a comprehensive
9 health care program -- that any plan should establish a
10 method of service payment. It is recognized that many
11 services are best provided without direct charge at the
12 time the service is rendered. Certain other services, on
13 the other hand, may tend to be over-utilized if there is
14 not a direct charge made. In order to conserve vital
15 health resources for the greatest good to all and to main-
16 tain costs at economic levels, it is strongly recommended
17 that utilization fees be established for certain services.
18 This plan has been approved at a meeting of the Saskatchewan
19 Hospital Association on the basis that provision would
20 have to be made to take care of need; it is no one's in-
21 tention to make a utilization fee any real deterrent to
22 receiving needed care.

23 THE CHAIRMAN: Was this matter of
24 utilization charges spelled out in any detail at your
25 Provincial meeting?

26 DR. SWANSON: No, sir, it is a prin-
27 ciple which we think is very important.

28 THE CHAIRMAN: Over what area does the
29 Association contemplate that a utilization charge would
30 be beneficial?



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particular concern to the Saskatchewan Hospital Association

during recent months and these appear at the bottom of

page three and on page four in this same series of notes

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health resources for the greatest good to all and to main-

tain costs at economic levels, it is strongly recommended

that a utilization fee be established for certain services

This plan has been approved at a meeting of the Saskatchewan

Hospital Association on the basis that provision could

have to be made for some rate of payment if no one else

is willing to pay a sufficient fee to pay itself

revenue needed

It is suggested that a rate of payment of

utilization charges be set out in any bill at once

Provincial government

It is suggested that it is a prin-

ciple which we cannot ignore is very important.

The Commission Over what time does the

Association anticipate that a utilization charge would

be levied?



1 DR. SWANSON: We have not developed
2 any scheme, but our thinking has been in the form of a
3 per diem utilization fee similar to that used in one or
4 two other provinces. We do not feel that would really
5 deter anyone receiving care and it was agreed in the
6 resolution that such fees could be waived at the discretion
7 of the hospital when it was felt this was a needy person
8 who could not pay the \$8.00 a day. We would point out
9 that \$1.00 a day is less than it would cost a person to
10 live at home, so this is a very small charge which we
11 think would serve to remind the patient that this was an
12 expensive thing. That is used in British Columbia and
13 Alberta now, a small charge. The other one we refer to as
14 enterprise dollars; this is a heading which is rather
15 meaningful; this was devised, I think, by the gentlemen of
16 the press when we were talking about this some months
17 ago. We believe there are ways, a good many ways, in which
18 hospitals can develop revenues not directly related to
19 patient care. Revenue from such enterprises as parking
20 areas, taxi stands, snack bars, barbering services and
21 so on can enable an expansion of needed services or pur-
22 chase of new equipment. I would have to add that this
23 would be a relatively small sum, but something that would
24 tend to give the hospital a feeling of independence.

25 The Saskatchewan Hospital Association
26 believes that it is important for such enterprise dollars
27 to be available and ~~that~~ such revenue should not be taken
28 into account by the insuring agency when determining per
29 diem payments. A further principle endorsed by the
30 Saskatchewan Hospital Association is that the earning of



1 enterprise dollars should not adversely affect the
2 quality of care. I might add to that, this would be a
3 relatively small amount, we would have no thought of
4 hospitals becoming great merchandise marts or things of this
5 nature and the hospital would remain very definitely as a
6 treatment centre. The hospital would not devote any major
7 part of its activity to this type of enterprise.

8 Personally, I believe this opinion is
9 reflected by a good many other administrators in this
10 Province. I first made contact with Saskatchewan through
11 the Canadian Hospital Association about ten years ago and
12 my first impression, having come from areas where there
13 was not this type of hospital insurance was one of amaze-
14 ment at the interest shown by all bodies of trustees and
15 administrators in not letting this go, so to speak, and
16 just raising salaries, raising costs because it was all
17 paid for by an outside agency. It is my personal opinion
18 that this interest has been blunted within the last ten
19 years and part of the reason for this, at least, is that
20 hospitals now depend for every dollar they get on Govern-
21 ment at some level, Provincial, Federal or local. This
22 tends to discourage the feeling of initiative and enter-
23 prise in their activities.

24 Again, I would say in suggesting enter-
25 prise dollars we are speaking only of a very small amount
26 in total.

27 THE CHAIRMAN: It did receive some
28 publicity at the time?

29 DR. SWANSON: Yes, sir.

30 THE CHAIRMAN: Was there any reaction



enterprises should not adversely affect the

quality of care. I might add to that, this would be a

relatively small amount, we would have no thought of

hospitals becoming great merchandising centers of this

nature and the hospital would remain very definitely as a

treatment center. The hospital would not devote any major

part of its activity to this type of enterprise

Personally, I believe this opinion is

reflected by a good many other organizations in this

Province. I first made contact with Saskatchewan

the Canadian Hospital Association about two years ago and

my first impression, having come from areas where there

was not this type of hospital enterprise was one of amazement

and at the same time shown by a number of trustees and

administrators in not taking this as so much of a

great thing, rather, it was all

paid for by an outside agency. It is my personal opinion

that this interest has been directed within the last two

years and part of the reason for this is that, as the

hospitals are used for other things, they get on government

and at some level, provincial, federal or local. This

tends to discourage the feeling of initiative and enter-

prise in their activities.

Again, I would say in suggesting enter-

prise efforts we are operating only at a very small amount

in total.

THE CHAIRMAN: It did receive some

publicity at the time.

MR. SWANSON: Yes, sir.

THE CHAIRMAN: Was there any reaction



1 from retail merchants' associations or commercial associa-
2 tions to it? Was there any reaction to the idea, I mean?

3 DR. SWANSON: I am not aware of any
4 reaction from retail people; we had reaction from others
5 among our own group, doctors and other who thought that
6 we were perhaps going off the rails. However, again I
7 would say that this was with no thought of developing
8 great shopping centres in the hospital, but to make a
9 few dollars that the hospital can call its own so if
10 they want to they can put in some added service for the
11 patients. It would not be a profit in the usual sense.

12 THE CHAIRMAN: Dr. Swanson, in dealing
13 with this matter of availability of beds and other hospital
14 problems, would you tell us briefly of an organization
15 that I think you were responsible for bringing into being,
16 a sort of coordinating council of hospitals in Saskatoon.

17 DR. SWANSON: Very briefly, this is
18 quite an informal arrangement which is participated in by
19 the three general hospitals and the sanatorium and occas-
20 ionally by the geriatric centre whereby the administrative
21 officers and one member of the board of each hospital
22 meets at relatively infrequent intervals, about twice a
23 year to discuss mutual problems and so on.

24 THE CHAIRMAN: This question of dup-
25 licating lists and that kind of thing may be one of the
26 problems that can be dealt with by such a council?

27 DR. SWANSON: It may be. I should
28 hasten to add it's quite understandable a physician anxious
29 to get his patient in to the hospital may well place his
30 name on two lists in the City where there might be a



from retail merchants' associations or commercial associations to it? Was there any reaction to the idea, I mean?

DR. SWANSON: I am not aware of any

reaction from retail people; we had reaction from others

among our own group, doctors and other who thought that

we were perhaps going off the rails. However, again I

would say that this was with no thought of developing

great shopping centres in one hospital, but to make a

few dollars that the hospital would have to live on.

They want to buy and put in some good people for the

patients. It would not be a problem to the usual centre.

THE CHAIRMAN: Dr. Swanson, in dealing

with this matter of responsibility of beds and other hospital

problems, would you tell us briefly of an organization

that I think you were responsible for bringing into being.

a sort of coordinating council of hospitals in Washington.

quite an informal arrangement which is participated in by

the three general hospitals and the Veterans and others.

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office and one member of the board of each hospital

meets at relatively infrequent intervals, about twice a

year to discuss mutual problems and so on.

THE CHAIRMAN: This question of sup-

porting funds and what kind of thing may be one of the

problems that can be dealt with by such a council?

needed to get it's share of the hospital's surplus

to get his patient in to the hospital and well place his

name on two lists in the City where there might be a



1 waiting period. It is just good competition, I suppose.

2 COMMISSIONER BALTZAN: Dr. Swanson,
3 in your communication of January 26th, 1962, page 3,
4 paragraph 3 (a) you ask us to see page 18 of the submission
5 that you had made. I would just refer to one aspect:

6 "A further factor which indirectly
7 contributes, although in a small way, to the length
8 of stay is the tendency of some practising physicians
9 to postpone discharge to suit the personal convenience
10 of the patient or the relative of the patient."

11 Dr. Swanson, please understand I am
12 not taking this out of the body of context of all the other
13 factors, but my first question is this: When the physician
14 leaves a discharge order that the patient may go that
15 afternoon could the administrators undertake the necessary
16 steps to get the patient away as per the physician's
17 order?

18 DR. SWANSON: I think they do.

19 COMMISSIONER BALTZAN: They do?

20 DR. SWANSON: Yes, sir.

21 COMMISSIONER BALTZAN: You have then
22 a vehicle to implement that move?

23 DR. SWANSON: Yes.

24 THE CHAIRMAN: You must qualify; "if
25 they have a place to go to."

26 DR. SWANSON: I was going to say that.
27 I would emphasize we are not trying to blame the doctors
28 or anybody else, but this order may be left and it may be
29 a little late, the doctor is a little busy that day and
30 it is late in the morning or early in the afternoon and the



1 nurse starts to arrange for discharge of the patient and
2 the patient may say "The last bus for home has gone" and
3 they let them stay until tomorrow morning. However, as
4 far as I know every effort is made to discharge the patient
5 at once following the order by the physician. Patients
6 are admitted and discharged on the order of a physician.

7 COMMISSIONER BALTZAN: Dr. Swanson,
8 in the very same connection, we all know this problem, but
9 I just want to speak of it. What happens if a relative
10 called in person or telephoned and insisted that the dis-
11 charge is inconvenient and, as you mention here, inconven-
12 ient or that there is no immediate accommodation and that
13 order cannot be filled by them, they cannot follow it.
14 You know doctors get that and I am sure hospitals get
15 that, what happens? Where are you stuck there?

16 DR. SWANSON: In our case which is
17 perhaps a bit different than the other hospitals because
18 we have such a large percentage of our patients who come
19 from outside the city from long distances, in many cases
20 our procedure would be to contact the physician in this
21 case and ask him what we can do about it and try to work
22 it out. It may be the physician will say, "Well, there
23 is a family in the city, send them to the uncle or aunt",
24 or something like that. We may have to agree to keep the
25 patient overnight. We do have, under the Act, the power
26 to charge the patient for that extra day's stay though
27 this, as you will readily understand, public relation-wise
28 is extremely difficult to enforce.

29 COMMISSIONER BALTZAN: What can you
30 suggest as a means for prompting this quicker action?



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they let them stay until tomorrow morning. However, as

far as I know every effort is made to discharge the patient

as once following the order by the physician. Patients

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charge is to be made and, as you mention here, in some

cases on that there is no immediate accommodation and that

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perhaps a bit different than the other hospitals because

we have such a large percentage of our patients who come

from outside the city from long distances, in many cases

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case and ask him what we can do about it and try to work

it out. It may be the physician will say, "Well, there

is a family in the city, send them to the hotel or send

or something like that. We may have to agree to keep the

patient overnight. We do have, under the Act, the power

to charge one patient for just extra days stay, enough

this, as you will readily understand public relations-wise

is extremely difficult to enforce.

COMMISSIONER BATTEN: What can you

suggest as a means for providing this further action?



1 DR. SWANSON: I think some steps have
2 already been taken that I mentioned; the activity in this
3 Province for the last year, the Thompson Committee, the
4 need for alternative facilities and so on and so the
5 public generally including the organization involved are
6 quite aware of this. Our suggestion really comes back
7 to this small submission that we believe a utilization
8 fee would stimulate a little quicker action on the part
9 of the people concerned. Secondly, that even if it does
10 not and assuming there is a certain amount of over-utiliza-
11 tion, it will help pay for it---assuming there is a
12 certain amount of utilization, utilization fee, even a
13 small one, would pay for this over-utilization.

14 I would like to put in one quick word
15 here and that is there are two evils and it is hard to
16 steer between them; one is the system which denies many
17 people the right and the facilities of hospital medical
18 care and that is bad. We are trying to correct that. In
19 trying to correct that, however, we may develop a system
20 where we produce a different kind of evil, over-utilization.
21 If we have to have an evil we would prefer the latter,
22 we would prefer there would be some over-utilization
23 rather than under-utilization. However, we would hope
24 that a small utilization fee might help us steer more
25 evenly between these two evils and not stop someone coming
26 who needs it. If there is still some over-utilization it
27 helps pay for it.

28 COMMISSIONER VAN WART: I would like
29 to ask a question on a little different phase. On page 8
30 of your summary to the Advisory Planning Committee, the

already been taken that I mentioned; the activity in this Province for the last year, the Thompson Committee, the need for alternative facilities and so on and so the public generally including the organization involved are quite aware of this. Our suggestion really comes back to this small contribution that we believe a utilization fee would stimulate a little greater action on the part of the people concerned. Secondly, that even if it does not and assuming there is a certain amount of over-utilization, it will help pay for it -- assuming there is a certain amount of utilization, utilization fee, even a small one, would pay for this over-utilization. I would like to put in one other word here and that is there are two evils and it is hard to steer between them one is the system which denies some people the right and the rationing of hospital beds, care and that is bad. We are trying to correct that. In trying to correct that, however, we may develop a system where we produce a different kind of evil, over-utilization. If we have to have an evil we would prefer the latter. We would prefer there would be some over-utilization rather than under-utilization. However, we would hope that a small utilization fee might help us steer more

who needs it. If there is still some over-utilization it helps pay for it.

COMMISSIONER VAN WAGEN: I would like to ask a question on a little different phase. On page 3 of your summary to the Advisory Planning Committee, the



1 last paragraph, you state:

2 "The cost of hospital operation has
3 been mounting steadily with the rapid progress in the
4 healing arts, advances in technical equipment, short-
5 ening of the work week, improvement in hospital ser-
6 vices generally and ---"

7 Along this line, turning to page 37
8 of the Brief itself in the middle of the page you state:

9 "The general hospitals of the Province
10 will be greatly concerned if fees presently allotted
11 for essential hospital care are diverted to assist
12 in the financing of the proposed medical care program."

13 Could you elaborate a little bit on
14 your fears there?

15 DR. SWANSON: Yes sir, and I believe
16 this type of point has been made by many others as well.
17 This actually goes back to the bottom of page 36 where we
18 suggest that in our experience the cost of operating a
19 comprehensive hospital care program has mounted a great
20 deal. This thing started out at \$7,000,000.00 and it is
21 now in the neighbourhood of \$40,000,000.00 a year. We
22 suggest that adding to this program and others in existence
23 and making a complete, comprehensive health program that
24 the initial cost will be exhausted very quickly. In any
25 event, even the initial cost will be high, and you
26 would foresee some danger in financing a very costly pro-
27 gram. Some of the existing programs may have very short
28 shift, shall we say, for at least a period of time. This
29 is our point and we are saying that with the introduction
30 of a more comprehensive care program one of the first



last paragraph, you agree?

"The cost of hospital operation has

viewed generally and --"

Along this line, turning to page 34

of the brief itself in the middle of the page you state:

"The general hospital of the Province

will be greatly concerned in fees presently allocated

for essential hospital care are devoted to assist

in the financing of the proposed medical care program.

Could you elaborate a little bit on

Dr. SWANSON: Yes sir, and I believe

this type of point has been made by many others as well.

This actually goes back to the bottom of page 30 where we

suggest that in our experience the cost of operating a

comprehensive hospital care program has averaged a gross

deal. This thing started out at \$7,000,000.00 and it is

now in the neighborhood of \$4,500,000.00 a year. We

suggest that adding to this program and others in existence

and making a complete, comprehensive health program that

the initial cost will be estimated very quickly. In any

event, even the initial cost will be high, and you

would foresee some danger in financing a very costly pro-

gram. Some of the existing programs may have very short

life, shall we say, for at least a period of time. This

is our point and we are saying that with the introduction

of a more comprehensive care program one of the initial



1 things to be sure of is that existing facilities are
2 at least maintained and preferably improved in the ways
3 which we suggest.

4 COMMISSIONER VAN WART: It is a real
5 danger, you feel, that there may be curtailment of
6 existing services for financial reasons, to operate
7 the other?

8 DR. SWANSON: I believe so, yes.

9 THE CHAIRMAN: Thanks very much, Dr.
10 Swenson and the gentlemen who are with you. As I said,
11 we are grateful for the fact that you did accept our
12 invitation to give us the information that we were asking
13 for, and it has been very valuable, and will be very
14 valuable. We are, of course, looking forward to hearing
15 in a much more general way from the Canadian Hospital
16 Association in the main brief in which the real hospital
17 problems, as such, will be dealt with, but it was this
18 area which we wished to develop here, and as we go
19 through the various provinces, so thank you again most
20 kindly for having answered our questions, and for having
21 given us so much valuable information and help.

22 THE CHAIRMAN: Now we have a submission
23 by the Saskatchewan Association of Chiroprodists.
24
25
26
27
28
29
30



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which we suggest.

COMMISSIONER VAN WART: It is a real

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DR. SWANSON: I believe so, yes.

THE CHAIRMAN: Thanks very much, Dr.

Swanson and the gentlemen who are with you. As I said,

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for, and it has been very valuable, and will be very

valuable. We are, of course, looking forward to hearing

in a much more general way from the Canadian Hospital

Association in the main body in which the real hospital

problems, as such, will be dealt with, but it was this

even when we wished to develop here, and as we go

through the various procedures, so that you again meet

kindly for having answered our questions, and for having

given us so much valuable information and help.

THE CHAIRMAN: Now we have a submission

by the Saskatchewan Association of Chiropractors.



SUBMISSION OF THE SASKATCHEWAN ASSOCIATION
OF CHIROPODISTS

Appearance: Dr. Earle R. Williams

THE CHAIRMAN: This will be Exhibit No.
111.

--- EXHIBIT NO. 111: Submission of The Saskatchewan
Association of Chiropodists.

DR. WILLIAMS: Mr. Chairman, members of
the Royal Commission on Health Services: my name is
Earle R. Williams and I am the Registrar of the Saskat-
chewan Association of Chiropodists and past president of
the Canadian Podiatry Association. I am here representing
the Podiatry profession in the province of Saskatchewan,
and to make the following submission regarding Podiatry
services. I sincerely hope same will be of value in
assisting the Royal Commission in its investigations
aimed at providing better health care for the people of
Canada.

The following brief of the Podiatry
profession includes (1) qualifications (2) existing
services and (3) recommendations by the profession.

1. Podiatry is the only recognized branch
of medicine devoted exclusively to the diagnosis and
treatment of ailments of the human foot. Podiatrists
are required to take one to two years of pre-medical arts
and sciences plus four years of study at an accredited
college of Podiatry. On successful completion of the
course of study he is granted his doctorate degree and



Appointed: Dr. E. W. Williams

The Chairman: This will be Exhibit No.

111.

--- EXHIBIT NO. 111: Submission of the said person
Association of Physicians

The Royal Commission on Health Services, by name is
Earle H. Williams and I am the Registrar of the Saskatchewan
Association of Physicians and past president of
the Canadian Society of Physicians. I am here representing
the Physicians Association in the province of Saskatchewan,
and to make the following submission regarding Podiatry
services. I sincerely hope some will be of value in
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3 is then eligible to sit for and pass Board examinations
4 in the province in which he hopes to practise, before
5 his name is added to the register and his licence issued.
6 Podiatry training as a specialized branch of medicine is
7 comparable to Dentistry. The graduate podiatrist is
8 eligible for membership in two research societies - first,
9 the American Academy of Chiropodists and second, the
10 American College of Foot Surgeons. Fellowships in both
11 these organizations may be had upon completion of further
12 training and study.

13 patients and 2. Podiatrists (synonym: Chiropodists)
14 are affiliated with over 1,000 hospitals and institutions
15 in the U.S. and Canada, including such renowned institu-
16 tions as Mayo Clinic, Bellevue Hospital, Philadelphia
17 General, New England Deaconess, Cedars of Lebanon, Temple
18 University, University of Virginia Medical School,
19 Toronto General, St. Joseph's and St. Michael's Hospitals
20 in Toronto; Vancouver General and St. Paul's Hospitals
21 in Vancouver, as well as dozens of Veteran's Administra-
22 tion and Army hospitals in the U.S.

23 3. Wherever podiatrists' services have
24 been utilized there has been a noticeable reduction in
25 bed requirements, since podiatrists are particularly
26 trained to keep their patients ambulatory; thus consi-
27 derably reducing costs (it costs about twice as much to
28 attend to a bed patient as an ambulatory patient).

29 4. Arthritis, polio, diabetes and arterio-
30 sclerosis are but a few of the conditions where podiatrists
have made notable contributions. By helping to prevent
infection and gangrene and keeping their patients ambulant,



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However podiatric services have been utilized there has been a noticeable reduction in the number of amputations in the U.S. trained to keep their patients ambulatory; this considerably reducing costs (it costs about twice as much to attend to a bed patient as an ambulatory patient).

Arthritis, polio, diabetes and other disorders are but a few of the conditions where podiatrists have made notable contributions. By helping to prevent infection and gangrene and keeping their patients ambulant,



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3 these people are more easily motivated for complete
4 rehabilitation, and at considerable savings in time and
5 money.

6 The following is a statement by Dr. T.A.
7 Crowther, head of the diabetic clinic at Toronto General
8 Hospital: "We are impressed with the great value of the
9 Podiatry Clinic in the care of the feet of the diabetic
10 (patient) with peripheral vascular disease. There is now
11 much less ulceration and infection occurring in the feet
12 of the clinic patients. It has also enabled some of the
13 patients with serious peripheral vascular disease to
14 postpone the time of amputation and in some to keep their
15 feet. The expert treatment and instruction in the care
16 of the feet given to these patients has added greatly to
17 their comfort. We expect that within the year there will
18 be more space available for the clinic. We are also
19 hoping that it will be possible to staff the Podiatry
20 Clinic two mornings a week. This care is a necessity
21 for the diabetic and it is important that it is extended
22 to more patients".

23 5. The Podiatry profession is governed
24 in the province of Saskatchewan by legislation passed in
25 April 1943 known as the 'Chiropody Profession's Act'.
26 Podiatrists in the province have had contracts with the
27 provincial Health Services Commission to provide foot care
28 for the aged and welfare cases; also, the Workmen's
29 Compensation Board since 1948.

30 6. The Saskatchewan Association of Chiro-
podists is an affiliated society of the Canadian Podiatry
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5. The Podiatry profession is governed in the province of Saskatchewan by legislation passed in April 1943 known as the "Chiropody Profession's Act". Podiatrists in the province have had contracts with the provincial health services Commission to provide foot care for the aged and welfare cases; also, the Workmen's Compensation Board since 1943.

6. The Saskatchewan Association of Chiropodists is an affiliated society of the Canadian Podiatry Association, and also the University of Saskatchewan.



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3 At present there is not a sufficient number of podiatrists
4 in Canada to meet the foot health needs of our people.
5 This we feel is due to the lack of Podiatry educational
6 facilities in Canada. At present, students must attend
7 one of the six accredited Podiatry colleges in the
8 United States. Many of these students stay in the U.S.A.
9 upon graduating.

10 7. Legislation Re: Podiatry varies
11 throughout the provinces of Canada. A national council
12 examination would rectify this condition and would allow
13 for more even distribution of podiatrists throughout the
14 nation. In keeping with the foregoing, we of the podiatry
15 profession present the following recommendations for your
16 consideration:

17 (1) That complete podiatry foot health
18 coverage be given to all Federal employees - civil
19 servants (military and others). This will assure the
20 civil servant of foot health care by a doctor of his
21 choice, and will reduce, to a degree, absenteeism. In
22 military hospitals this service would reduce the number
23 of in-hospital patients either by shortening their stay
24 or by treating them on an out-patient basis.

25 (2) That an executive council member of
26 the Canadian Podiatry Association be included as a member
27 in any committee established for the health and welfare
28 of the Canadian people. An example of this is the appoint-
29 ment of Dr. Edward L. Tarara, staff Podiatrist of Mayo
30 Clinic to the American Advisory Committee on Health and
Medical Welfare, White House Conference on Aging.

(3) That a national council examination



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3 be established for Podiatry in Canada to insure a
4 uniformly high standard of licensure and registration
5 throughout the country.

6 (4) That a Federal grant be given to a
7 Canadian University for the establishment of a Canadian
8 College of Podiatry using the existing University facilities
9 as is already done in Dentistry. Thus giving the
10 youth of our country an opportunity in an uncrowded
11 profession. (at present, there is one Podiatrist to every
12 100,000 population in Canada).

13 It is an uncrowded profession, yet very
14 necessary. Canada moves on its feet.

15 We respectfully request that the Royal
16 Commission on Health Services consider and investigate
17 the possibilities outlined in this brief so that all of
18 our Canadian citizens might be able to receive foot-
19 health care, not just some of them.

20 If there are any further questions pertaining
21 to the practice of Podiatry, which you might have in
22 mind, I will do my best to answer them.

23 THE CHAIRMAN: How many of the profession
24 have you in Saskatchewan at the present time?

25 DR. WILLIAMS: Five at present.

26 THE CHAIRMAN: And they are located at
27 Saskatoon and Regina?

28 DR. WILLIAMS: That is right.

29 THE CHAIRMAN: Elsewhere?

30 DR. WILLIAMS: Well, we did have a man in
Prince Albert, but he is not there now.

THE CHAIRMAN: You suggest the establishment



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It is an unexcelled profession, yet very

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3 of facilities for training. Have you gone into any
4 figures on the question of cost?

5 DR. WILLIAMS: Using the existing facili-
6 ties, either in the east like Toronto University, or
7 the University of Saskatchewan, or the University of
8 British Columbia, with what they have there, and the
9 classes that are held similar to pharmacy and dentistry,
10 we can operate on approximately, say, a 55,000-dollar
11 grant to any one university in Canada for the establish-
12 ment of a ---

13 THE CHAIRMAN: Is that 55,000 a year?

14 DR. WILLIAMS: A year.

15 THE CHAIRMAN: What would that provide?

16 DR. WILLIAMS: That would provide, it
17 would have to be done in a university, where you have
18 university facilities, and your students would take your
19 similar anatomical, pharmaceutical, chemistry and medical
20 and so on. These facilities already exist. It is just
21 including more students that is all, to attend these
22 classes. It is a matter of utilizing some of that to
23 pay for any special ~~extra~~ classes that professors there
24 have to give in keeping with the podiatry profession,
25 because for this profession more stress is placed on
26 dealing with the foot and leg, so they would have to
27 give a greater number of classes. Also, you would have
28 to fit, say, in the west here, you would have to move
29 suitable lecturers from the east, or from the United
30 States to Canada. You would need approximately three
specialists in the podiatry profession. That is, you
require a physician, a mechanical orthopaedist, and an



of facilities for training. Have you gone into any

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DR. WILLIAMS: Using the existing facilities,

either in the east like Toronto University, or the University of Saskatchewan, or the University of British Columbia, with what they have there, and the classes that are held similar to pharmacy and dentistry, we can operate on approximately, say, a \$5,000-a-year grant to any one university in Canada for the establishment of a

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THE CHAIRMAN: Is that \$5,000 a year?

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would have to be done in a university, where you have university facilities, and your students would take your similar anatomical, pharmaceutical, chemistry and medical and so on. These facilities already exist. It is just including more students that is all, to attend those classes. It is a matter of utilizing some of that to pay for any special extra classes that professors there have to give in keeping with the podiatry profession, because for this profession more stress is placed on dealing with the foot and leg, so they would have to give a greater number of classes. Also, you would have to fit, say, in the west here, you would have to move suitable lecturers from the east, or from the United States to Canada. You would need approximately three specialists in the podiatry profession. That is, you require a physician, a mechanical orthopedist, and an



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3 administrator. It could possibly be that it wouldn't
4 quite be that much. We have allowed that amount because
5 we feel that would include everything. Usually in the
6 university towns, or the cities where our colleges are
7 established, like in San Francisco, we just concluded a
8 one-and-a-half million dollar hospital there in connection
9 with the college, and many of the teachers there are in
10 outside practice as well, but they give a class at the
11 university. They are staff members. So you could
12 utilize the staff members in any large area where the
13 podiatrists are concentrating. Where there is a greater
14 number of practitioners. If it was done down east, you
15 wouldn't have to bring anyone to Canada at all from the
16 United States. In fact, much of the work, a lot of the
17 scientific work done in the United States today in
18 podiatry, much of it has been contributed by Canadian
19 podiatrists, in research and especially in mechanical
20 therapeutics.

21 COMMISSIONER VAN WART: Is it mostly in
22 the out-patient, or the in-patient parts of the hospital
23 that you work?

24 DR. WILLIAMS: In both, it is combined.

25 COMMISSIONER VAN WART: Do you know in
26 some specific hospital such as, say, the Toronto General,
27 do they go in as in-patients? I notice you quote a
28 statement from the Diabetic Clinic. It mentions that
29 you have the out-patient. Do you know whether they go
30 as in-patients or not?

31 DR. WILLIAMS: In the beginning when that
32 is carried on.



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4 COMMISSIONER VAN WART: The members of
5 your profession enter the wards and give treatments in
6 a hospital like the Toronto General?

7 DR. WILLIAMS: The patients are taken to
8 the clinic.

9 COMMISSIONER VAN WART: The in-patients
10 are taken to the out-patient, and given the treatment
11 in the out-patient?

12 DR. WILLIAMS: That is right.

13 COMMISSIONER BALTZAN: Dr. Williams,
14 your presentation was most informative. Do you prescribe
15 drugs on prescription, such as vaso-dilators, etc? That
16 has to do with the circulation and other things related
17 to locomotion.

18 DR. WILLIAMS: Well, that depends. We
19 are part of a health team. If there are systematic
20 conditions prevalent in a patient, we work with the
21 family physician, and in a case of that two of us would
22 get together and decide which is the best vaso-dilator
23 to use. We are licensed to prescribe vaso-dilators,
24 such as niacin. You can get fairly good dilation with
25 Vitamin E.

26 COMMISSIONER BALTZAN: You do prescribe
27 drugs by prescription signed by yourself?

28 DR. WILLIAMS: Oh, yes, but not narcotics.
29 We do not come under the narcotic law in Canada.

30 THE CHAIRMAN: Thank you very much, Dr.
Williams. Your brief will receive our consideration,
and we are grateful to you for having come before us and
explained the matter so clearly.



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4 DR. WILLIAMS: I thank you for listening
5 to me, and I know that you must be very tired after all
6 these briefs. You have a whole lot ahead of you yet,
7 all the way across Canada, and I hope God gives you
8 strength.

9 MR. HALL: Mr. Chairman, there is a commu-
10 nication from the Town Clerk of the Town of Saltcoats
11 to be read into the record. It is addressed to the
12 Royal Commission on Health Services: "In the presentation
13 of briefs to the Commission, the Council of the Town of
14 Saltcoats endorses and wishes to present the following
15 resolution;

16 'The Council of the Town of Saltcoats
17 submits that the national health program
18 should include chiropractic care on an
19 equal basis with other recognized
20 healing arts'.

21 The Commission's consideration in this
22 regard is appreciated, Yours truly".

23 It is signed "Stan Spokes", Town of Salt-
24 coats Town Clerk".

25 THE CHAIRMAN: That will be incorporated
26 into the record.

27 Is there any other person present who
28 wishes to make a submission? There being no further
29 submissions to be heard here in Regina, we will bring
30 these public hearings to a close, and in doing so I
want to express on behalf of the Commission our thanks
to those who did make submissions, because I think we
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resolution;

"The Council of the Town of Saltspring submits that the national health program should include chiropractic care on an equal basis with other recognized health care."

"The Commission's consideration in this

regard is appreciated. Yours, truly,"

It is signed "John G. Hall, Town of Saltspring."

THE CHAIRMAN: That will be incorporated

into the record.

Is there any other person present who

wishes to make a submission? There being no further submissions to be heard here in Regina, we will bring

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TORONTO, ONTARIO

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5 analysis very helpful indeed, and we are grateful to all
6 who have taken the time and trouble to make the submis-
7 sions which we received here. So the hearing is now
8 adjourned.

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10 --- Adjournment.
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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

EDMONTON

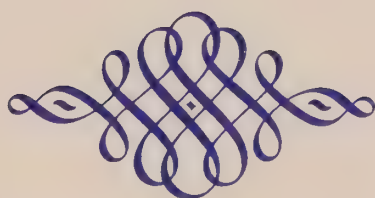
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VOLUME NUMBER :

22

DATE :

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I. D. X.
The hearing
held at Edmonton, Alberta,
12th day of February, 1922

THE PROVINCE OF ALBERTA
#889

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THE PROVINCE OF ALBERTA

4897



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TORONTO, ONTARIO

ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held in Edmonton, Alberta,
12th day of February, 1962.

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL -- Chairman

MISS ALICE GIRARD, R.N.

DR. DAVID M. BALTZAN

PROF. O.J. FIRESTONE

MR. M. WALLACE McCUTCHEON, Q.C.

DR. C.L. STRACHAN

DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. N. LAFRANCE

ROYAL COMMISSION ON ALIEN SERVICES

Proceedings of the hearing
held in Edmonton, Alberta,
12th day of February, 1982.

COMMISSION MEMBERS:

CHIEF JUSTICE BERTT M. HALL -- Chairman

MISS ALICE GIBSON, P.C.

DR. DAVID M. B. LITVIN

MR. M. WALLACE MONTGOMERY, Q.C.

DR. C. L. STACHURA

DR. ALBERT J. W. ...

LEGAL COUNSEL:

DR. BILLY JOSEPH

DIRECTOR OF RESEARCH:

PROF. ...

SECRETARY:

... H. ...



Edmonton, Alberta,
Monday, February 12th,
1962.

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11- THE CHAIRMAN: Ladies and gentlemen, if
you will come to order we will begin our public hearings
for the Province of Alberta. We are very happy to see
so many of you here because this indicates that public
interest in these hearings is as great in Alberta as it
has been in the other six provinces we have already
visited. The number of persons and organizations who
have indicated an intention to appear before us is quite
lengthy and even formidable and this also indicates the
public interest. We have set up a tentative agenda which
we may or may not be able to adhere to completely but we
will try to allot as much time as appears reasonably
necessary for the proper presentation of any submission
and elucidation of any supplementary information that may
be required arising out of this submission.

The first item for this morning is a
submission on behalf of the Government of the Province of
Alberta. I recognize Mr. J.J. Frawley and I am very happy
to welcome also the Honourable Minister of Health for
Alberta, Dr. Donovan Ross.

--- EXHIBIT NO. 112: Submission of the Province of
Alberta.

SUBMISSION OF THE PROVINCE OF ALBERTA

THE CHAIRMAN: I understand you will be
opening the submission, Mr. Frawley?

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MR. FRAWLEY: Mr. Chairman and members of the Commission: I am appearing for the Province of Alberta this morning and the brief of the Government of the province will be presented by the Honourable J. Donovan Ross, Minister of Health. Dr. Ross has with him this morning a number of advisors and I shall read into the record the names of these advisors.

Dr. M.G. McCallum, Deputy Minister of Health;

Mr. H.E. Homan, Assistant Deputy Minister of Health;

Dr. L.J. de Vann, Personnel Superintendent, Provincial Training School;

Mr. J.D. Campbell, Director, Hospitals Division;

Dr. F.B. Rodman, Director, Medical Services Division;

Dr. A.R. Schrag, Clinic Psychiatrist, Provincial Guidance Clinic;

Dr. R.R. MacLean, Director, Division of Mental Health, Provincial Mental Hospital;

Dr. H.H. Stephens, Director, Division of Tuberculosis Control, Aberhart Sanatorium;

Mr. H.L. Hogge, Director, Division of Sanitary Engineering;

Dr. R.D. Stuart, Director, Provincial Laboratories, University of Alberta;

Dr. C.W. McPhail, Director, Dental Health Services;



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Mr. D.W. Rogers, Deputy Minister of
Welfare;

Mr. W. Maday, Assistant Business Admini-
strator, University of Alberta Hospital;
Dr. T.C. Michie, Superintendent, Ponoka
Mental Hospital;

Mrs. Dorothy L. Smith, Director, Public
Health Nursing, Division of Local Health
Services;

Mrs. J.C. Bailey, Nursing Consultant,
Maternal & Child Health, Division of
Local Health Services.

With that brief introduction I would ask
Dr. Ross to make his submission to the Commission.

THE CHAIRMAN: Dr. Ross, the presence of
so many of your senior officials is an indication of the
care that you have gone to in the preparation of this
submission and indicates again the interest of the
Province of Alberta. The fact that you are going to
place at our disposal information from all of these
associates is something we appreciate very much.

HON. DR. ROSS: Mr. Chairman and members
of the Commission: first of all, I would like to express
the regrets of the Premier, Mr. Manning; he and my
colleagues are busy this morning on estimates and getting
prepared for the opening of the Legislature. I only
trust in my absence that my estimates do not suffer. The
Premier has asked me to personally express his regrets
and, on his behalf, to welcome you and the members of
your Commission to the Province. We trust you will have



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3 a pleasant time in your stay in Alberta and trust that
4 out of these hearings will come benefits for the people
5 of Canada.

6 I would also like to say that the people
7 I have with me this morning represent a portion of what
8 I personally consider is a very capable public government
9 service looking after the interests of our people in this
10 province. I have only been in this position for some
11 four-and-a-half years but I have found these people and
12 the others in the service that I am responsible for a
13 dedicated group of people. I think the people of Alberta
14 can be proud to have these men looking after their
interests.

15 1. The Alberta Government welcomes this
16 opportunity to submit for your study and consideration
17 certain information that we trust will be of assistance
18 to you in assessing the health services of our nation as
19 they pertain to Alberta. We hope our submission will
20 enable you to decide on the nature and extent of any
further steps that should be considered in this field.

21 2. The Government of Alberta views with
22 very real concern the progressive intrusion of the Federal
23 Government into areas in which it has no constitutional
24 right to be involved. Under The British North America
25 Act of 1867, the responsibility of the health of the people
26 of Canada was assigned to the jurisdiction of the provinces.
27 Since 1948, with the introduction of federal health
28 grants, up to the recent federal-provincial hospital plan,
29 there has been a progressive encroachment into provincial
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3 We do not, in any way, deny the useful nature of the finan-
4 cial assistance provided to the various provinces for
5 health purposes but we hold that a far more desirable
6 procedure and one in keeping with respect for constitutio-
7 nal jurisdiction would have been for the Federal Government
8 to provide its assistance by the payment to the provinces
9 of supplementary funds under the federal-provincial tax
10 rental agreements which funds could then have been used by
11 the provincial governments within their own field of juris-
12 diction and in such manner as they felt would be most bene-
13 ficial to their people in the field of public health care.
14 This procedure would not have involved any greater expendi-
15 ture of federal funds and would, in fact, have avoided
16 considerable cost of administration both at provincial
and federal levels.

17 3. During the past quarter of a century
18 in Alberta there has been a steady and progressive develop-
19 ment of programs related to such diseases as tuberculosis,
20 mental illness and retardation, poliomyelitis, cerebral
21 palsy, arthritis, cancer, diabetes, rheumatic fever and
22 pensioner medical services, etc., as will be seen as we
23 present to you a full report of the various divisions of
our public health services.

24 4. The basic objective of our Government's
25 program has been to make sure that if such services were
26 needed they will be available to all of our citizens under
27 circumstances which will avoid the imposition of an unduly
28 heavy financial burden on the patient or his family. To
29 this end, the basic principle underlying our public health
30 program is to subsidize essential health services to the

we do not, in any way, deny the useful nature of the financial assistance provided to the various provinces for health purposes but we hold that a far more desirable procedure and one in keeping with respect for constitutional jurisdiction would have been for the Federal Government to provide its assistance by the payment to the provinces of supplementary funds under the federal-provincial tax rental agreements which funds could then have been used by the provincial governments within their own field of jurisdiction and in such manner as they felt would be most beneficial to their people in the field of public health care. This procedure would not have involved any greater expenditure of federal funds and would, in fact, have avoided considerable cost of administration both at provincial and federal levels.

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3 extent necessary to bring them within the financial reach
4 of our citizens but without removing the individual's
5 proper responsibility to pay for some reasonable part of
6 the costs involved out of his own resources.

7 5. In Alberta there has been a very good
8 reception to and utilization of the method of prepayment
9 for medical services under Medical Services Incorporated
10 and through the Blue Cross for supplementary hospital
11 services over and above those paid for from public revenue
12 under the federal-provincial hospitalization program.

13 6. Under the present hospitalization
14 program as it applies in Alberta, the costs are met by
15 payments from four sources:

16 1. A four mill tax on real property
17 assessed at municipal level and which
18 represents the municipal ratepayers'
19 contribution to the overall cost of the
20 hospitalization program.

21 2. Direct payments from the provincial
22 treasury of the actual hospital operating
23 costs up to an approved ceiling, for
24 which payments the provincial treasury
25 is reimbursed in the amount of somewhat
26 less than 50% by the Federal Government
27 under the provisions of the federal-
28 provincial hospitalization agreement.

29 3. A payment of co-insurance ranging
30 up to \$2.00 per day paid for by each
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4 such are required to make up any excess
5 costs over the ceiling incurred in the
6 operation of a hospital.

7 7. I wish to point out that the Federal
8 Government has consistently refused to recognize the co-
9 insurance feature of the Alberta hospitalization program as
10 equivalent to the premiums paid by residents in those
11 provinces using the premium systems even though they both
12 represent the patient contribution to the financing of the
13 plan.

14 8. The Federal Government's refusal to
15 recognize funds paid by Alberta citizens who are hospital
16 patients in the same manner that hospital insurance
17 premiums are recognized in other provinces constitutes,
18 in our opinion, a gross injustice and imposes an addi-
19 tional financial burden on the Alberta provincial treasury.

20 9. In the case of a relatively small
21 number of citizens who are financially unable to pay the
22 moderate co-insurance fees, these are taken care of by the
23 province under its policy of ensuring that none of our
24 people shall be denied essential hospital services through
25 lack of financial resources.

26 10. It is our submission that this
27 arrangement under which those unable to pay are taken care
28 of by society collectively while those who are able to pay
29 are required to bear a reasonable portion of the total
30 costs with government subsidization being provided only to
the extent necessary to bring the services within their
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3 individual financial responsibility is removed. The
4 Government of Alberta has consistently opposed so-called
5 socialized health and medical services, believing that
6 such programs are incompatible with the rights and respon-
7 sibilities inherent in a free and democratic society and
8 that they have basic weaknesses:

9 1. When the total cost of a health or
10 any other social service is paid directly
11 by the state it creates the false impres-
12 sion that such services are free to the
13 citizens of the province or country.
14 The fact is, of course, that the same
15 citizens are paying for the service
16 whether they pay it directly in whole or
17 in part, or by taxation. The aggregate
18 cost is more rather than less when the
19 state is interjected between the citizens
20 receiving the service on the one hand
21 and paying the bill as taxpayers on the
22 other.

23 2. The socialization of health services
24 is destructive to the traditional and
25 desirable patient-doctor relationship and
26 the preservation of human dignity in this
27 very personal field. These circumstances
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5 necessary stimulus to young men and
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7 to enter such vocations. We believe
8 that only by maintaining a system in
9 which private enterprise and individual
10 initiative and personal responsibility
11 combined with whatever financial subsidi-
12 zation is required from society collec-
13 tively, can the best interests of our
14 people in the field of health be success-
15 fully and adequately served.

16 11. We trust that these concepts which
17 recognize fundamental human needs, human rights and human
18 responsibilities will be of help in your consideration of
19 the important matters which are the subject of your
20 enquiry.

21 MR. FRAWLEY: Mr. Chairman, what are your
22 wishes with regard to the balance of the brief as we go
23 into a description of the various health services conducted
24 by the Province of Alberta?

25 THE CHAIRMAN: Mr. Frawley, there are
26 certain aspects of the original opening statement of the
27 Province of Alberta that we would like to enquire into a
28 little more. I think, as those enquiries are made, it
29 may carry us -- it will undoubtedly carry us into the body
30 of your submission at various stages. When that procedure
has been completed, if there are aspects of the submission
that, in your view, have not been fully covered, then we
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4 on the other elements, if you think they have not been
5 covered and should be specifically referred to, you are
6 perfectly free to bring them up and call any evidence
7 from any of those associated with yourself and Dr. Ross
8 this morning.

9 MR. FRAWLEY: You have in mind at this
10 stage to stop and put questions to Dr. Ross on his
11 opening submission?

12 THE CHAIRMAN: I think so. There are
13 certain general principles involved here which have not
14 been available, in a sense, in the other provinces to date.
15 For instance, the matter of the patient contribution, the
16 matter of collecting a land tax which is unique to Alberta.
17 There are certain situations that are unique to Alberta
18 and which we assume Alberta regards as being sound and,
19 therefore, it will help us in the overall picture. We
20 want to develop these phases, these things which are unique
21 in Alberta at this time.

22 Now, any questions that are put are put
23 to elicit information and to try to help us out. It is
24 possible that a question might appear to have implications
25 that are not intended; the questions are not intended to
26 embarrass or do anything to yourself as a Department but
27 to bring out what is involved here.

28 The first matter that I would like to
29 mention is your very forthright statements in paragraph 2
30 that the Government of Alberta is concerned with the
progressive intrusion of the Federal Government into
areas in which it has no constitutional right to be
involved. You are not the only province, of course, that

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3 makes that statement. Having made that we must acknowledge
4 that you have also gone on to discuss all the aspects of
5 the constitution as it exists facing reality in 1962.
6 Now, the Commission, of course, as you will appreciate,
7 is not unaware of the constitutional difficulties and
8 aspects of the subject of health services in Canada because
9 the Order in Council under which we act specifically
10 enjoins us to stay in the constitutional limits as set up
11 by the British North America Act. When the Government of
12 Alberta says that the job would be better done, I am para-
13 phrasing your statement, would be better done by handing
14 money over to the province or making money available to
15 the province does that involve, in your view, a basis such
16 as a per capita basis or under what basis is it? Supposing
17 you were going to scrap the present situation, what would
18 you want in its place?

18 HON. DR. ROSS: Mr. Chairman, I will
19 recognize that Section 91 of the B.N.A. Act might have
20 various interpretations made of it. However, the inter-
21 pretation we have made is that health is a provincial
22 responsibility as is education, welfare and many others,
23 though we have merely felt that this being its constitu-
24 tional responsibility, then we felt it is of necessity
25 our job to do it and to carry it out. We are not saying
26 if the B.N.A. Act was changed to make it a joint responsi-
27 bility - we are not saying we would have objection to that,
28 but since there is, in our way of thinking, a constitution-
29 al responsibility given to the province removed from the
30 Federal Government then it is to that constitutional
principle we are concerned. If, as you said, we



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4 scrapped what we are doing and decided how could we then
5 assist in the provision of a program of health services
6 for the people of Canada, then our feeling that as we
7 have done in our hospitalization program and our educa-
8 tional program here, that there should be a basic minimum
9 program for the people of Canada that should be supported
10 then by the Federal Government to all the provinces and
11 with this it would have to be on a per capita basis. With
12 this were a number of inequities where certain grants may
13 have been available to provinces who, because their own
14 resources were inadequate, they couldn't pick them up.
15 We think the people of Canada are one people. There are
16 not merely ten provinces. It has been our contention that
17 all the people of Canada should be on a basically sound
18 and proper level of health services to which a contribution
19 would be made by the Federal Government and that the pro-
20 vincial revenues then could be utilized in whatever manner
21 they developed themselves to provide the kind of program
22 they wished for their own provincial people.

23 THE CHAIRMAN: Would you say - if you
24 wish to remain seated for the answers, go ahead - would
25 that involve the same per capita payment to all provinces
26 alike in your view?

27 HON. DR. ROSS: I would feel, sir, there
28 is going to be a lot of work that will have to go into
29 what is considered in the opinion of people the basic
30 services required and the cost that is going to be
involved in that. I think you are going to have to relate
the per capita payment to the ability of other areas, at
least in part.



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THE CHAIRMAN: Would you say - if you
wish to refer to the 47,000, go ahead - would
that involve the same per capita payment to all provinces
like in your view?
MR. ROSS: I would feel, sir, there
is going to be a lot of work that will have to go into
what is considered in the opinion of people the basic
services required and the cost that is going to be
involved in that. I think you are going to have to relate
the per capita payment to the ability of other areas, at
least in part.



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4 THE CHAIRMAN: So you think what we call
5 the "have provinces" would support in part the minimum
6 program in the "have nots"?

7 HON. DR. ROSS: I think, sir, through
8 years of past experiences that this has been a factor and
9 as you are aware we were treated in a manner a little bit
10 different than might have been considered proper by some
11 of the other provinces that are poorer in natural resource
12 revenue, even though it was to the detriment of Alberta
13 to be treated in a different manner. We recognize we
14 are in a different position.

15 THE CHAIRMAN: Well now, moving on to
16 page 2, in connection with the last sentence of the first
17 paragraph, the top paragraph: "The basic principle under-
18 lying our public health program is to subsidize essential
19 health services". Then you go on to say: "...without
20 removing the individual's proper responsibility to pay
21 for some reasonable part of the costs involved". Are
22 you speaking there of a contribution in advance of illness
23 or as an ill person making a contribution?

24 HON. DR. ROSS: This, sir, relates to
25 the development of our program of health services in
26 Alberta over the past number of years. We have been
27 developing our mental hospital services to which the
28 patient, for which the patient is charged a dollar a day.
29 Perhaps you may wish to ask some other people questions
30 on that later. They are entitled to that service whether
they can pay or not, but there is a charge made when they
use the service. This has been done with our program for
mentally defective children. This has been done in our

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4 hospitalization program where a charge has been made when
5 they utilize the service. This has not been done in tuber-
6 culosis.

7 THE CHAIRMAN: In mental health you have
8 that?

9 HON. DR. ROSS: In mental health we have
10 that charge when the patient requires the service.

11 THE CHAIRMAN: No other charge?

12 HON. DR. ROSS: No other charge.

13 THE CHAIRMAN: What happens if the
14 patient remains a patient until that patient dies? What
15 happens to the estate? Is the estate liable?

16 HON. DR. ROSS: The estate is.

17 THE CHAIRMAN: For the debt to the
18 province?

19 HON. DR. ROSS: The estate is liable for
20 the debt to the province.

21 THE CHAIRMAN: For the dollar a day or
22 the whole bill?

23 HON. DR. ROSS: For the patient's charge,
24 a dollar a day. In spite of that there have been millions
25 written off the books of the accounts during my brief stay.

26 THE CHAIRMAN: You don't make a distinc-
27 tion as to whether the heirs of the patient live within or
28 without the province? At least one other province does.

29 HON. DR. ROSS: There is nothing in our
30 Act - in other words, if it is the wife who might have
been deserted the estate, in other words, the husband is
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3 THE CHAIRMAN: That would be this dollar
4 a day?

5 HON. DR. ROSS: That is the dollar a day.
6 That is restricted to the dollar a day. It isn't the total
7 amount of the cost of the service, no.

8 THE CHAIRMAN: Alberta has this principle
9 by which a four mill tax on real property is levied?

10 HON. DR. ROSS: That is right, sir.

11 THE CHAIRMAN: That necessarily means
12 that those who don't own real estate are not contributing
13 to that part of the cost. How does a person who does not
14 own real estate make his contribution as distinct from a
15 person who does?

16 HON. DR. ROSS: Well, Mr. Chairman, this
17 is a question asked me on many a platform. My answer is,
18 I have yet to find a landlord that doesn't at least,
19 collect the cost of tax in his rent. I personally feel
20 whether they own property or not they are paying taxes on
21 the property they rent, so they are paying their share of
22 the four mill that is collected for hospital services.

23 THE CHAIRMAN: And that tax, how is it
24 collected?

25 HON. DR. ROSS: It is collected by the
26 municipalities.

27 THE CHAIRMAN: By the municipalities?

28 HON. DR. ROSS: It is a municipal assess-
29 ment including the four mill for hospitalization which is
30 active and chronic hospitalization. It is collected by
the municipalities and channelled into the provincial
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3 THE CHAIRMAN: If it isn't collected,
4 if it is a year when tax collections are poor ---?

5 HON. DR. ROSS: The treasury would be
6 short.

7 THE CHAIRMAN: Is it the treasury or the
8 fund available for hospitalization that is short?

9 HON. DR. ROSS: No, it is the treasury
10 that is short. I hope my fund is not short.

11 THE CHAIRMAN: Mr. McCutcheon has just
12 mentioned a matter. By what principle do you get unifor-
13 mity throughout the province?

14 HON. DR. ROSS: There is equalized assess-
15 ment by the Municipal Affairs Department, equalized rates
16 across the province. It has been going on for the last
17 few years so that the valuation of the property right
18 across the province is the same. We have sort of a code
19 of assessment.

20 THE CHAIRMAN: Relative valuation?

21 HON. DR. ROSS: It is a valuation by
22 assessors who are trained to assess property the same in
23 Pepper as in Grand Prairie or in Edison as out in Wain-
24 wright so we have a fairly equal type of assessment on
25 equivalent property right across the province.

26 THE CHAIRMAN: You have direct payment
27 from the provincial treasury up to an approved ceiling.
28 By whom is that ceiling arrived at?

29 HON. DR. ROSS: The hospitalization
30 program is a division of the Department of Health. Mr.
Campbell is the Director of the Hospitals Division. He
has prepared his assessment each year which I then submit



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4 for an appropriation, and then this is based on our past
5 year's experience of the cost of operation of hospitals.
6 The Hospitals Division of my Department is responsible
7 for the payment, monthly payment on account to each hospi-
8 tal in the province, based on the previous year's cost of
9 operation of the hospital. There is a ceiling imposed for
10 each hospital that is related to that cost, and then there
11 are semi-annual adjustments made during the year for
12 increased costs that occur during the year when the other
13 financial statements come in from each hospital. These
14 are all gone over by the Hospitals Division. Mr. Campbell
15 and his people have the final statements. The ceiling is
16 arrived at on proportion. Mr. Campbell will be able to
17 clarify this picture better for you later when we get into
18 the hospitalization area. We feel that this ceiling is
19 a control from the unending spiralling hospital costs that
20 will go on unless there is some restraint imposed. We
believe it is an adequate amount to give a quite high
quality of hospital care.

3 21 THE CHAIRMAN: Then you determine what
22 the hospitals will have to operate on within the year
23 rather than the hospital?

24 HON. DR. ROSS: It is based on their
25 past operational costs with adjustments for the increased
26 cost of the year.

27 THE CHAIRMAN: Then we come to the
28 principle of co-insurance. We are very much interested
29 in that because it has been suggested and we have heard
30 submissions for and against it. You are using it here.



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3 You call it co-insurance. Do you regard it as a deterrent
4 charge as well?

5 HON. DR. ROSS: I would say yes to that
6 question, Chief Justice Hall. This has been utilized in
7 Alberta for many, many years. Even before our hospitalization
8 program there were municipal hospitals throughout our
9 province who had it, what was called a dollar-a-day
10 program, which was a patient contribution. Certainly in
11 those early days that dollar a day was a greater percentage
12 than it is today of the total cost of the hospital services
13 received. We believe it has some deterrent effect.
14 Having practised in general medicine myself for a number
15 of years and having patients come to me, pensioners for
16 whom it was paid, some who had Blue Cross or other form
17 and others who had none, when I suggested hospitalization
18 to them, on a number of occasions they would say "How much
19 is it going to cost for our hospitalization", even the
20 two dollars a day. I would say personally I do feel there
21 is some deterrent effect from misuse of hospitalization
22 or unnecessary use of hospitals.

21 THE CHAIRMAN: Over-utilization?

22 HON. DR. ROSS: Over-utilization, perhaps
23 not as much as it could be if we increased it more, since
24 it is not shared.

25 THE CHAIRMAN: Well now, if there is to
26 be such a thing as a comprehensive health service plan
27 would you advocate the use of a deterrent charge?

28 HON. DR. ROSS: Personally, sir, I would.
29 I personally feel that to retain the quality of the
30 service of our medical or of our health services that we



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3 have got to prevent quantity demand. I think that if the
4 individual receiving it must pay some part for their
5 initial service, at least, they will think twice before
6 having unnecessary calls made upon this health service.

7 THE CHAIRMAN: You would carry that into
8 the field of physician service as well?

9 HON. DR. ROSS: Personally, I would, sir.

10 THE CHAIRMAN: And drug costs and any
11 other services that might be included in the comprehensive
12 health service plan?

13 HON. DR. ROSS: I think there has to be
14 some patient contribution made for this service whether
15 it is in a first payment up to a certain amount related
16 to their spendable income, that at least, it would put
17 some damper on the demand that they would otherwise make
18 if there was no cost to them.

19 THE CHAIRMAN: This co-insurance charge
20 for the two dollars, in some instances, and a dollar-and-
21 a-half in others - we are not concerned about that, I
22 mean that procedural difference, as I understand, that is
23 collected by the hospitals. I suppose that is on admis-
24 sion or discharge?

25 HON. DR. ROSS: On discharge.

26 THE CHAIRMAN: Or when they can get it.
27 What happens if that is not paid?

28 HON. DR. ROSS: If they don't collect?

29 THE CHAIRMAN: On whom does the responsi-
30 bility fall to collect this co-insurance?

31 HON. DR. ROSS: The responsibility falls
32 on the individual hospital through which patients have



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other services that might be included in the comprehensive health service plan?

NOW, DR. ROSS: I think there has to be some patient contribution made for this service whether it is in a first payment up to a certain amount related to their condition. And at least, it would not come under the demand that they would otherwise make if there was no cost to them.

THE CHAIRMAN: This co-insurance charge for the two parties, in some instances, and a dollar-and-a-half in others - we are not concerned about that, I mean that procedural difference, as I understand, that is collected by the hospital. I suppose that is on admission or discharge?

NOW, DR. ROSS: On admission or discharge.
THE CHAIRMAN: Or when they are out of it, not happens if that is not said?

NOW, DR. ROSS: If they don't collect?

THE CHAIRMAN: On whom does the responsibility fall to collect this co-insurance?

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3 received services and some hospitals, perhaps, may ask
4 for deposits when the patient goes in, but normally when
5 the patient is discharged they are presented with the bill
6 for the costs that were related to co-insurance.

pw 7 If they cannot collect it and they
8 utilize the collection procedures outlined by the hospitals
9 program, then at the end of six months a portion of that
10 is written off as a bad debt. At the end of the year --
11 at the end of another six months -- the balance is written
12 off. If at a later date this is collected by the hospital
13 it becomes hospital revenue.

14 THE CHAIRMAN: It is recaptured as
15 revenue?

16 HON. DR. ROSS: For the hospital.

17 THE CHAIRMAN: Yes, for the hospital.

18 HON. DR. ROSS: Otherwise, their
19 co-insurance is an offset revenue that is deducted from
20 their total operational cost.

21 THE CHAIRMAN: I am not sure I have
22 understood you. It has been written off ---

23 HON. DR. ROSS: It has been written off.

24 THE CHAIRMAN: --- after a year, and
25 therefore somebody then comes in and pays them \$2. Does
26 the hospital have to account for that \$2 to the hospital
27 plan?

28 HON. DR. ROSS: Not after a year.

29 MR. CAMPBELL: I think we might add
30 here that when that is written off, it is not written off;
it is paid by the Provincial Government and then if any
subsequent collections are made they are offset against



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3 the claim which they would have in another period.

4 THE CHAIRMAN: That is, the amount
5 collected goes back to the credit of treasury?

6 MR. CAMPBELL: That is right, and it is
7 relatively insignificant as far as the amounts are
8 concerned.

9 THE CHAIRMAN: If we go into the whole
10 field of co-insurance and deterrent charge, it may
11 become a substantial figure in the overall picture.

12 Well then, with those three items: muni-
13 cipal levy and the direct payments and this co-insurance
14 charge, when collected -- if that is not enough to pay
15 the operating cost of the hospital, what happens then,
16 if there is a deficit?

17 HON. DR. ROSS: Well, in the submission
18 of the estimates to the Legislature, sir, I mean, we
19 commute the cost that we are going to entail as a Depart-
20 ment to pay for hospital services.

21 THE CHAIRMAN: But you are doing that in
22 advance?

23 HON. DR. ROSS: We are doing that in
24 advance, yes.

25 THE CHAIRMAN: But at the end of the year
26 you have an actuality; you have an audited account which
27 is either in balance, in deficit, or in profit.

28 HON. DR. ROSS: If it is in deficit, we
29 need money and have to go back to the treasury.

30 THE CHAIRMAN: But the hospital ---

HON. DR. ROSS: The hospital is paid
operational payments each month on account, and final

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3 settlement at the end of the year with an audited finan-
4 cial statement.

5 THE CHAIRMAN: Therefore, is a hospital
6 account bound to be in balance at the end of the year?

7 HON. DR. ROSS: They may have excess
8 cost over and above our ceiling and they have to meet
9 those costs themselves.

10 THE CHAIRMAN: They have to meet those
11 costs themselves?

12 HON. DR. ROSS: Additional municipal
13 levies, as such, are required to meet any excess charge
14 over the ceiling incurred in the operation of a hospital.
15 This comes about at the end of the year with the final
16 adjustments made by our Hospitals Division for each indi-
vidual hospital.

17 THE CHAIRMAN: Hospital X has finished
18 up the year with a deficit of, say, \$15,000 ---

19 HON. DR. ROSS: And if it is over the
20 ceiling, they have to find the money from the municipal
area.

21 THE CHAIRMAN: And they can find it by
22 passing the hat, or in any way they wish, but they may
23 go to the municipality?

24 HON. DR. ROSS: If it is a municipally-
25 operated hospital, they can submit a requisition to the
26 municipality which is approved by our Department to indi-
27 cate why they are requisitioning the municipality for
28 these additional requirements, over and above the four
million the municipality requisitions.

29 THE CHAIRMAN: That goes into the next
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3 year's levy?

4 HON. DR. ROSS: Yes, that goes into the
5 next year's levy.

6 THE CHAIRMAN: What about the voluntary
7 hospital that has not a municipal base?

8 HON. DR. ROSS: The voluntary that has
9 not a municipal base, we say that as operators of the
10 hospital, since we believe that our funds are adequate to
11 provide the necessary care, if they have excess costs,
12 they have to find the money to meet it themselves.

13 THE CHAIRMAN: What do you mean by excess
14 costs?

15 HON. DR. ROSS: Excess costs are those
16 over and above the ceiling that is set for that particular
17 hospital in relation to their previous year's operational
18 costs; additional amounts paid because of increased cost
19 of services generally across the province for hospitaliza-
20 tion in the current year, and any final adjustments made
21 by our Hospitals Division for that hospital when their
22 financial statement is submitted.

23 THE CHAIRMAN: Have the voluntary hospitals
24 access to municipal levies?

25 HON. DR. ROSS: They have, under our
26 Alberta Hospitals Act, which was brought in last year.

27 THE CHAIRMAN: That is Chapter 36 of 1961?

28 HON. DR. ROSS: That is right, and as I
29 have indicated there will be amendments coming forward
30 that I hope will be approved by legislature this year in
respect to modification of that that make it mutually --
it would have to be a mutual agreement between the

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it would have to be a mutual agreement between the



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3 hospital and the ---

4 THE CHAIRMAN: That is Section 11 that I
5 see in the Act here. That is the hospital and the munici-
6 pality have mutually to agree on this report.

7 HON. DR. ROSS: They have to mutually
8 agree on this, that if there are excess costs by a privately-
9 owned hospital that is serving a municipal area, and
10 there is mutual agreement, then the municipality can pay
11 the excess costs to this private hospital.

12 THE CHAIRMAN: I am a little concerned
13 about sub-section 2 of it which appears to divest the
14 voluntary hospital of control of this management if it
15 makes that request.

16 HON. DR. ROSS: As I say, there are
17 amendments that I hope to have put forward this year.

18 THE CHAIRMAN: Well then, the section
19 as it reads now would appear to take control of manage-
20 ment out of the hospital and hand it over to the majority
21 appointed by the municipality.

22 HON. DR. ROSS: This has caused some
23 concern among the Sister-operated hospitals and they have
24 made representation to the Department for modification
25 which is being considered.

26 THE CHAIRMAN: But if a voluntary hospital
27 has a deficit and it is not able to get a municipality to
28 mutually agree to pick, or to help pick up this deficit,
29 it has got to find it out of its own resources?

30 HON. DR. ROSS: Yes. I think you are
aware, sir, that in the Sister-operated hospitals here
the Sisters are all paid salaries for their work in the



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3 hospitals, which goes into the Sisters' fund and that is
4 a fund which they have to use.

5 If there are excess costs, they use it
6 for that. If there are no excess costs, it is their fund
7 to do with what they wish. It is their municipal treasury.

8 THE CHAIRMAN: The salaries, that is,
9 belong to the Sisterhoods. They are doing the same
10 service as another nurse on the ward and they get a compa-
11 rable salary?

12 HON. DR. ROSS: That is right.

13 THE CHAIRMAN: So that if the amount that
14 Mr. Campbell's Department determines is not sufficient to
15 operate the hospital, then they have got to pick up the
16 deficiency out of their resources?

17 HON. DR. ROSS: We believe, sir, that as
18 operators of a hospital they have the responsibility for
19 their operation and they are aware of the sums of money
20 that are available to them, and certain adjustments that
21 are made.

22 We think this is a job of administration
23 that they have to face up to the same as any other municipi-
24 pal hospital.

25 THE CHAIRMAN: I think you refer to that
26 in paragraph 140 on page 43, where you say:

27 "Although controls were imposed govern-
28 mentally, it entailed the maintenance of
29 local autonomy as far as possible. In
30 order to accomplish this end the ceiling
which is applied covers a relatively
broad area within which the local



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hospital board maintains its autonomy provided that the area under consideration, as far as costs were concerned, remained within the ceiling level established".

Well now, the matter of the continuation of the voluntary hospital is a subject upon which we have received representations and it is regarded as being one of some importance.

Do you see the application of this principle of deficits being paid from private resources as leading eventually to the elimination of the voluntary hospital?

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HON. DR. ROSS: No, sir, I do not. If I felt that the operation of our plan would bring about the elimination of the voluntary hospital, I would be much concerned personally because we have in Alberta some 30 private hospitals, several Protestant ones, the others -- some which are other Protestant ones -- but the majority are the Catholic Sisters. They have served the people of Alberta over many years and have served them well.

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When we brought our program into effect and when we instituted in 1959 our capital cost program, we indicated then that all of these hospitals would be treated on the same basis as far as the acceptance of the capital debt, the existing capital debt on their buildings and hospitals were concerned, the provision of funds for the renovation, for the enlargement, or for the replacement of those private hospitals, the same way as we would with municipal hospitals. I think that we have demonstrated



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3 that in our programs in Alberta in the past several years.

4 THE CHAIRMAN: What I am trying to get
5 at is in the operation what could the extra costs be in the
6 operation of a hospital that Mr. Campbell's department
7 would not foresee at the beginning of a year?

8 HON. DR. ROSS: Well, several years ago,
9 sir, as you are aware, hospitals were on a 48-hour week.
10 They dropped to a 44-hour week. Most of the hospitals in
11 Alberta today are on a 40-hour week. This increased
12 number of bodies that are required for hospitalization
13 has brought about an increased cost of operation. There
14 are practically four shifts required to operate a hospital
15 today, instead of about two-and-a-half shifts when I was
16 a younger man taking medicine. And this has been recog-
nized in the increasing cost of operation over the years.

17 When we started out in 1958, we had \$10.70
18 ceiling; in 1959, that went up to \$11, and to \$12 the next
19 year, and \$12.72 the past year.

20 In other words, there has been an increa-
21 sing amount, and we pay on a rate of bed day basis. Every
22 hospital bed is paid for for 365 days a year.

23 THE CHAIRMAN: That is every rated bed?

24 HON. DR. ROSS: In other words, the rated
25 beds in the hospital. Let us take some of the hospitals
26 here. 328 beds, 342 beds. They get their amount times
27 -- the number of beds times 365 days. This is based on
28 our principle that society collectively should provide
29 the cost of that facility present and waiting to do its
30 job; that when the patients use it, then the additional
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ing amount, and we pay on a rate of bed days basis. Every

bed day is paid for for 300 days a year.

The Chairman: That is every third day?

WON. DR. ROSS: In other words, the patient

is in the hospital, and it is counted as a bed day.

WON. DR. ROSS: They get their amount times

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3 paid for by the patient and our rated bed day payments,
4 we believe, are realistic to give a good quality of care
5 that the hospitals should be able to maintain themselves.
6 There may be other things that come into it.

7 THE CHAIRMAN: For instance?

8 HON. DR. ROSS: You want to know what
9 they are?

10 THE CHAIRMAN: Yes, I would like to know
11 what some of them are.

12 HON. DR. ROSS: I think, sir, that
13 perhaps we can get the hospital people here to do that.
14 They may point them out, and Mr. Campbell may be able to
15 mention some that we ran into.

16 I am thinking in terms of a hospital
17 where emergency services have been a high cost area,
18 because they have been over-utilized by doctors and
19 patients rather than the doctor's office.

20 THE CHAIRMAN: Yes.

21 Now, if we accept that, and I do accept
22 it from you, Dr. Ross, and that results in a deficit in
23 the hospital, why should the voluntary hospital have to
24 pay that out of their wages?

25 HON. DR. ROSS: If it was the same in a
26 municipal hospital, they go back to the ratepayer.

27 THE CHAIRMAN: Yes, they go back to the
28 ratepayer and take it out of the ratepayers' pockets, but,
29 taking it out of some private person's pocket ---

30 HON. DR. ROSS: We say the owners of the
hospital have the responsibility of the administration of
their hospital, and it is the same way in a business. At



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3 least, I believe that hospitalization is big business,
4 and that businessmen today, if they see there are certain
5 costs that are going to put them in a loss position, they
6 are going to do something about it before they end up in
7 the red. I think the hospitals have to do the same thing.

8 THE CHAIRMAN: Are you suggesting that
9 the hospitals should police the medical profession?

10 HON. DR. ROSS: I am suggesting that the
11 doctors, and I have said this to my medical confreres,
12 that the doctors operate in the hospitals as a privilege,
13 and not as a right. That is, the owners of the hospital
14 are the administrators of the hospital, and I feel if the
15 doctors are mis-using areas of their hospital, that are
16 putting them into areas of excess costs, I think they have
17 to bring this to the doctors' attention through their
18 medical staff.

19 THE CHAIRMAN: What happens to the patient
20 while this discussion is going on between the doctor and
21 the hospital? The emergency patient, we are talking about.

22 HON. DR. ROSS: There is a difference
23 between an emergency patient and the emergency section of
24 a hospital being mis-used or being over-used for things
25 that are not emergencies.

26 THE CHAIRMAN: I am just coming now to
27 what I think I want to ask, and that is if it is your
28 settled opinion about this matter of control, and you
29 have a section in your brief here called the "Technique
30 of Control". It is paragraph 136 on page 42.

This brings us to this discussion of a
very important principle in terms of a state-administrated



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least, I believe that hospitalization is big business,
and that businessmen today, if they see there are certain
costs that are going to put them in a loss position, they
are going to do something about it before they end up in
the red. I think the hospitals have to do the same thing.
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very important principle in terms of a state-administered



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4 program, whether it is of hospitals or of physicians'
5 services or of any other health services.

6 You say, in paragraph 136:

7 "In the basic planning underlying the
8 establishment of the Federal Provincial Hospitalization
9 Plan in Alberta an attempt was made to build into the
10 administrative procedures as strong a degree of control
11 of the respective areas as possible".

12 Now, is it your view that this statement
13 is a statement of principle in terms of the operation of
14 a state-controlled health service, whether it be hospitali-
15 zation, physicians' service, or any other?

16 HON. DR. ROSS: This depends entirely,
17 sir, on how you develop your program of health services,
18 and whether you utilize the various groups of people in
19 your community who are capable of providing those services
20 to the people.

21 THE CHAIRMAN: I might not have made
22 myself plain. You see, it is being urged upon us at
23 various places that there should be a national comprehen-
24 sive health services plan on a compulsory basis in some
25 areas and on a voluntary basis in other areas. It is
26 being urged very broadly that there should be a comprehen-
27 sive health services program. What I am putting to you
28 is, from your experience in the operation of the hospitali-
29 zation plan in which you say that you found a strong
30 degree of control necessary, do you envisage that the same
principle of a strong degree of control would be necessary
in any comprehensive health services plan?

HON. DR. ROSS: I would say that it would

1001. DR. ROSS: I would say that it would

in any comprehensive health services plan.

principle of a strong degree of control would be necessary degree of control necessary, do you envisage that the same ration plan in which you say that you found a strong

is, from your experience in the operation of the hospital- 50
ative health services program. What I am putting to you

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areas and on a voluntary basis in other areas. It is

ative health services plan on a compulsory basis in some

various places that there should be a national compulsion- 30
myself plan. You see, it is being waged upon us at

The CHAIRMAN: I might not have made

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and whether you utilize the various groups of people in

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3 be necessary within the groups that were giving the
4 service.

5 THE CHAIRMAN: It is inherent in the
6 idea of a comprehensive plan?

7 HON. DR. ROSS: I think it is inherent
8 in the provision of any type of a program where public
9 funds are being spent.

10 THE CHAIRMAN: I mean a state-controlled
11 program.

12 HON. DR. ROSS: Well now ---

13 THE CHAIRMAN: Just as a hospitalization
14 plan is.

15 HON. DR. ROSS: I am not sure - I am
16 saying this only to try and help put my position forward.
17 I am not sure whether in this province that we have a
18 government-controlled health service program that we may
19 utilize funds that are available from the collective
20 treasurers to utilize the facilities, the personnel who
21 are capable of providing the facilities. Under the terms
22 of an agreement we have done this in Alberta for our
23 pensioner medical services.

24 THE CHAIRMAN: I follow you completely
25 there.

26 HON. DR. ROSS: They have to keep the
27 controls within control as in a government agency.

28 THE CHAIRMAN: What you may do in Alberta
29 is one thing, accepting your premise that health is a
30 provincial matter, other provinces may have different
ideas. Now, we are concerned with getting your viewpoint,
if we can. I mean, if it is reasonable we should have it



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THE CHAIRMAN: It is inherent in the

idea of a comprehensive plan?

104. DR. ROSS: I think it is inherent

in the provision of any type of a program where social

forces are being agent.

THE CHAIRMAN: I need a state-controlled

program.

THE CHAIRMAN: Just as a hospitalization

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104. DR. ROSS: I am not sure - I am

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I am not sure whether in this province that we have a

government-controlled health service program that we have

outside forces that are a liability from the collective

104. DR. ROSS: I follow you completely

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THE CHAIRMAN: What you say is in Alberta

is one thing, and your province that health is a

provincial matter, other provinces may have different

ideas. Now, we are concerned with getting your viewpoint.

104. DR. ROSS: I mean, it is as possible as we should have it



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3 based on your experience with the hospitalization plan as
4 to whether if we have a state-controlled plan for medical
5 services, does that necessarily involve a strong degree
6 of control by the state? That is what the doctors are
7 saying, you know that. We are trying to test to see if
8 that stands up in the light of experience.

9 HON. DR. ROSS: The controls, I would
10 say, that have been used here, we have recognized what we
11 consider is an appropriate amount of money to be spent on
12 hospitalization services - I am sorry if I am getting off
13 the track.

14 THE CHAIRMAN: What you say is this: it
15 is really on page 43 where you say that you can spend any
16 amount you like as long as you do not spend more than
17 \$12.42 or some other figure.

18 HON. DR. ROSS: It may not even go as
19 high as that with some hospitals.

20 THE CHAIRMAN: I was reminded of the old
21 story about Henry Ford when he first started to make cars;
22 he said you could have them any colour you like as long as
23 the colour was black.

24 HON. DR. ROSS: Yes. What we have
25 attempted to do, as we have said, is to provide an adequate
26 amount of money to give a good service and to leave the
27 way in which they spend that money their own concern. If
28 they want to spend more money in one area of the hospital
29 than another as long as the patients get good quality care,
30 I think it is their responsibility. We have not tried to
say "You can only spend this much for drugs and this much
for this and this much for that". We have left them their



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to whether it we have a state-controlled plan for medical
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3 autonomy of operation within limits. Since Mr. Campbell
4 was partly responsible for the development of our program
5 prior to its implementation in Alberta, he may have some
6 comments on that that may clarify your question.

7 THE CHAIRMAN: If you wish to make a
8 statement now it would be quite appropriate.

9 HON. DR. ROSS: Well, all these people
10 are here to be asked any questions that you wish. Of
11 course, the opinions of all the people here may not be
12 my own opinion but they are free to make it.

13 MR. CAMPBELL: I have sat and listened to
14 your questions and the basic philosophy which you have
15 indicated we did attempt to apply. It is very difficult
16 to pay a bill and not call the shot as far as how it is to
17 be spent. This was a very distinct problem with which we
18 were faced.

19 THE CHAIRMAN: Is that inherent in any
20 government-operated plan of health services?

21 MR. CAMPBELL: I would not wish to make
22 a statement in regard to that.

23 HON. DR. ROSS: Perhaps I could go on
24 from there. I think you have all the certain principles
25 that are comprehended by the authority which is the Legis-
26 lature or the House of Commons for a program and I think
27 you must admit if you are an administrator you stay within
28 the amount that is there.

29 THE CHAIRMAN: Would that be the same if
30 you had X dollars for physicians' services?

31 HON. DR. ROSS: You can only buy as many
32 services as those X dollars would purchase from the people



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prior to the implementation in Alberta, we may have some
comments on that that may clarify your point on.

THE CHAIRMAN: If you wish to make a

statement now it would be quite appropriate.

MR. CAMPBELL: Yes, I will make a statement.

are here to be asked any questions that you wish. Of
course, the opinions of all the people here may not be
my own opinion but they are going to make it.

MR. CAMPBELL: I have said and intended

your questions and the basic philosophy which you have

indicated we did attempt to do. It is very difficult

to say a bill or not call the end as far as how it is to

be done. This was a very difficult question with which we

THE CHAIRMAN: Is that answer to my

question, or would you like to say more?

a statement in regard to that.

MR. CAMPBELL: Perhaps I could go on

from there. I think you have all the certain principles

of the State of Canada for a program and I think

you must admit if you are in a position to say that in

the amount that is there.

THE CHAIRMAN: Would that be the end of it?

Do you have any questions for my friends, gentlemen?

MR. CAMPBELL: You can only say so much

services as those X dollars would purchase from the people



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3 prepared to give the services.

4 THE CHAIRMAN: And somebody has to sit on
5 the lid?

6 HON. DR. ROSS: I think somebody has to
7 sit on the lid.

8 THE CHAIRMAN: And that means control
9 over those giving the services?

10 HON. DR. ROSS: That means control within
11 the groups giving the services and an attempt to get
12 control within the people demanding the services.

13 THE CHAIRMAN: That is an educational
14 process?

15 HON. DR. ROSS: Very definitely an educa-
16 tional process but I think our co-insurance itself
17 provided some incentive to boost your over-utilization
18 of services.

19 THE CHAIRMAN: Now, on this matter, and
20 perhaps I am reverting for the moment but at paragraph 137
21 which is immediately below "Technique of Control", the
22 last sentence on the page:

23 "There was imposed an overall maximum
24 pro-rated bed day which applied to the
25 hospitals where costs were in excess of
26 such maximums".

27 Is that a universal rate or applicable
28 to individual hospitals?

29 HON. DR. ROSS: Yes, there is an overall
30 maximum rate. There is a total ceiling which this year,
in 1961, was \$12.72. We permitted a 3% increase in costs
which brings that up to \$13 and a few cents.



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prepared to give the services.

THE CHAIRMAN: And somebody has to sit on

the 11th?

JOE. D. ROSE: I think somebody has to

sit on the 11th.

THE CHAIRMAN: And that means control

over those giving the services?

JOE. D. ROSE: That means control within

the groups giving the services and an attempt to get

control with the people demanding the services.

THE CHAIRMAN: That is an educational

process?

JOE. D. ROSE: Very definitely an educational

process. I think our organizations have

provided some services to local and over-servicing

of services.

THE CHAIRMAN: Now, on this matter, I

propose I am reporting for the rest of the afternoon I

will be talking about "The Role of the 11th", the

last sentence on the paper.

"There was a meeting on the 11th, maximum

proposed and day which resulted to the

possibilities where we were in excess of

and maximum."

Is that a universal rate or applicable

to individual hospitals?

JOE. D. ROSE: Yes, there is an overall

maximum rate. There is a total ceiling which this year,

in 1981, was \$12.75. We permitted a 3% increase in costs

which brings that up to \$13 and a few cents.



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3 THE CHAIRMAN: That was to take care of
4 increasing wages and that kind of thing amongst others?

5 HON. DR. ROSS: Yes.

6 THE CHAIRMAN: And increases in wages,
7 that is a matter of bargaining, is it not, with employees,
8 conciliation boards and all the rest of it? I mean, a
9 hospital has not full control over its wages or do you
10 consider it has?

11 HON. DR. ROSS: No, it has not full
12 control over its wages. However, I think, and I am unpopu-
13 lar when I say it, but I think there is need for all
14 hospitals to look at the productiveness of the staff. In
15 other words, it is easier, I think, to go into the demands
16 for paying another body on the hospital staff, to add
17 additional bodies than to try and get increased work out
18 of the ones that are there. This is something that hospi-
19 tal operations, administrators, have to look at; that is,
20 increased productivity applies just as much in hospital
21 operation as any business.

22 THE CHAIRMAN: Would it be in order to
23 ask on behalf of this Commission for the per diem rate
24 established for each hospital in the province in the past
25 two or three years? Perhaps since 1958 since the program
26 started?

27 HON. DR. ROSS: You would want the rated
28 bed day amount in each of the hospitals?

29 THE CHAIRMAN: I do not expect to have it
30 here now.

31 HON. DR. ROSS: We can have our people
32 draw that out.



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THE CHAIRMAN: And send it to our Secretary in due course.

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HON. DR. ROSS: Yes. You will see a variation across the hospitals indicating various modes of administration and administrative capabilities.

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THE CHAIRMAN: Now, in hospital operation you now cover in-patient service?

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HON. DR. ROSS: Yes.

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THE CHAIRMAN: Do you pay for all drugs used in in-patient services or have you a list of excepted drugs for which the plan does not pay?

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HON. DR. ROSS: No, there are some drugs that the pharmacy advisory committee set up by the College, the hospitals association and the divisions indicate should be charged to the patient. There is only a matter of, I would say, probably half-a-dozen drugs which are not considered by this committee to be exceptable at the present time. I would say as a broad statement that all our drugs are covered.

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THE CHAIRMAN: That is five or six exceptions; are they widely used at all, do they amount to much?

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HON. DR. ROSS: Perhaps Dr. Rodman might ---

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DR. RODMAN: I have not been on that committee.

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MR. MADAY: We have excluded actase which is an expensive and not proven drug. Basically it is about the only one - thrombolysin is the one that has



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4 been in this group.

5 THE CHAIRMAN: You see, we have found
6 some provinces excluded quite a few and some provinces
7 covered everything. You virtually cover everything here?

8 HON. DR. ROSS: I would say we virtually
9 cover everything that is a recognized useful drug for
10 patients.

11 THE CHAIRMAN: When we come to the out-
12 patient service, what is the situation there?

13 HON. DR. ROSS: The situation at present
14 is that out-patient hospital facilities are only provided
15 by our government for our pensioner group. In other words,
16 the people who are in receipt of this card that identifies
17 them to doctors, dentists, optical assistance and also
18 out-patient services at the hospitals. Blue Cross also
19 include that, so many people in Alberta are carrying Blue
20 Cross as supplementary hospital benefits now for hospital
21 out-patient services.

22 THE CHAIRMAN: I maybe read that some
23 consideration or studies have been given to out-patient
24 services?

25 HON. DR. ROSS: We have been making a
26 study with the possibility that out-patient services may
27 be included at some time.

28 THE CHAIRMAN: As a shareable cost?

29 HON. DR. ROSS: Yes.

30 THE CHAIRMAN: With the Federal Government?

HON. DR. ROSS: Yes. When we looked at
this situation back in 1958 under our agreement with the
Federal Government and during that first nine months of



been in this group.

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THE CHAIRMAN: When we come to the out-

patient service, what is the situation there?

HON. DR. ROSS: The situation at present

is that out-patient hospital facilities are only provided

by our government for our general group. In other words,

the people who are in receipt of this care that identifies

them to doctors, dentists, optical assistance and also

out-patient services at the hospitals. Blue Cross also

include that, so many people in Alberta are carrying Blue

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Federal Government and during that first nine months of



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3 our program there were the two areas, the hospitals of
4 chronically ill long-term patients and the out-patient
5 people that we felt were creating problems in our active
6 hospitals for two dollars a day, maybe three dollars.
7 These dollars make up a lot of out-patient services you
8 have to pay a fair amount for outside. The next year we
9 entered into the chronic care because we felt it was a
10 heavier financial burden than the out-patient services
11 but the chronic disability was a long-term expensive
12 thing and we included it under our plan.

13 THE CHAIRMAN: Having excluded out-
14 patient services in your agreement with the Federal Govern-
15 ment have you found that that fact has led to increased
16 utilization of hospital services, of in-patient services?
17 Perhaps someone else in your Department could answer.

18 HON. DR. ROSS: I suspect it has, and as
19 a practising physician of a few years back I think I
20 would have to plead guilty in some cases of having utilized
21 hospital facilities for diagnostic services taking into
22 account the economic circumstances of the family. Some-
23 times this sort of thing can be justified because the
24 atmosphere of a hospital is a better place for evaluating
25 a patient's condition rather than for a lot of tests done
26 on an out-patient basis. I think I can justify my actions.

27 THE CHAIRMAN: It becomes a very important
28 question to the Commission because of the cost. As you
29 appreciate, the overall cost of hospitalization in Canada
30 is about \$770,000,000 or \$775,000,000 a year and the
utilization of the acute beds in the general hospitals, if
they are used on behalf of out-patients when they should



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4 not be, to the point of even one day, involving a percen-
5 tage point of one day, could mean \$75,000,000 to
6 \$100,000,000 a year. This is an important problem. What
7 is your view on the desirability of including out-patient
8 services under the hospitalization plan with a view to
9 saving hospital beds that are now used by out-patients
when they perhaps should not be?

10 HON. DR. ROSS: I think you have to
11 take into account that here where we are paying on a rate
12 bed day basis payments to hospitals are not going to be
13 too much different if their occupancy rate is relatively
optimal, say, 80% or 90%.

14 THE CHAIRMAN: Your rated bed is what,
15 roughly 80% of occupancy?

16 HON. DR. ROSS: We use 80% although our
17 metropolitan hospitals are running at from 85% to 90%
18 and some above that.

19 MR. CAMPBELL: I believe you asked the
20 question as to determination of rated beds; this is
21 primarily determined on the basis of standards which have
22 been set and are agreeable between the province and the
23 Federal Government as far as space is concerned. There
24 are other factors which enter into it so that you may have
25 set up in a given hospital more beds than rated beds. We
26 do not encourage that but the base of our own beds is on
27 that. Our payments are varied somewhat between. On the
28 level of occupancy there was a factor built into the
29 ceiling plan that took care of the difference in level of
30 occupancy but from 80% to 100%, that carried the whole
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3 THE CHAIRMAN: Dr. Ross, did I understand
4 from you that because of this rated bed payment method
5 it did not matter that an out-patient who did not belong
6 in the hospital really went there?

7 HON. DR. ROSS: The only difference it
8 makes is this: that it denies the use of that bed to
9 somebody who needs an active bed and puts a pressure on
10 for more active beds than should be built.

11 THE CHAIRMAN: To be constructed.

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12 HON. DR. ROSS: Yes. We were concerned,
13 we believe that there is an optimum number of beds
14 required for annual hospital and necessary care. Some of
15 these beds are being utilized by patients who could use
16 out-patient facilities for diagnosis. Now, I feel if we
17 had the necessary money at the present time, we would have,
18 we would probably have an out-patient service in. We
19 considered it.

20 THE CHAIRMAN: For instance, the
21 Province of Alberta operates out-patient service and the
22 shareable cost with the Dominion Government, and we heard
23 that they think it is very beneficial in the sense of
24 bed utilization.

25 HON. DR. ROSS: I would feel it will
26 make some difference. I am personally not convinced,
27 at least, in Alberta it will make the difference we
28 think it will. I think we must recognize the fact that in
29 the provision of out-patient services that all the facili-
30 ties available for diagnostic services must be able to be
utilized rather than to increase areas in hospitals. I
think, I know in discussions in this area before I said



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3 I felt that the private, recognized diagnostic services
4 provided by private sources, in other words, the doctors
5 who have set up laboratories and carry out a large part
6 of the diagnostic services in the community, that is in
7 the urban centres, at least, that these should be able
8 to be included under such a plan and be utilized because
9 first of all, if we don't have them you would be denying
10 them the opportunity to earn their living. You would be
11 increasing the cost by increased structural facilities
12 and increased equipment in your hospitals and denying
13 people the choice of going to a place that would be more
convenient, that they may be accustomed to.

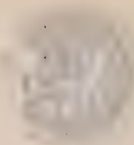
14 THE CHAIRMAN: Another aspect of health
15 services, nursing services - Dr. Ross, as I understand it
16 the basic agreement between the province, various provinces
17 and the Dominion, is that necessary nursing services are
18 a shared cost.

19 HON. DR. ROSS: Yes.

20 THE CHAIRMAN: What is the policy here
21 with respect to special nurses when ordered by the atten-
ding physician?

22 HON. DR. ROSS: If it is considered
23 necessary in the interest of the patient by the physician
24 and that is agreed to by the hospital authority who is the
25 authority for employing people, then they would be employed
by the hospital and paid for by the hospital.

26 THE CHAIRMAN: By the hospital. The
27 physician says X is very sick and must have a nurse at
28 his or her side continuously, I mean that should be the
29 physician's recommendation. You say that there is some
30



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responsibility on the hospital to check that?

HON. DR. ROSS: Well, another thing is that the hospital has to supply that. I don't think that you can just have a doctor say, "Look, I want three private nurses put on this patient" without being questioned. They are not the ones that are going to pay for it.

THE CHAIRMAN: The hospital?

HON. DR. ROSS: Yes.

THE CHAIRMAN: In your interpretation isn't necessary nursing services within the agreement between the province and the Dominion?

HON. DR. ROSS: Is it necessary nursing services?

THE CHAIRMAN: That is the language of the agreement.

HON. DR. ROSS: Necessary nursing services, this could be necessary nursing services for the patient. If they cannot be provided for out of the staff in the hospital at the time then they would have to hire someone. That would be put - I think that is a question again for the nursing administrator in the hospital in working out her staff needs to fill patient needs.

THE CHAIRMAN: Would you visualize the nursing administrator overruling the doctor?

HON. DR. ROSS: I would think that it would be very unlikely that she would. I think it would be unlikely that she would, but I think she has the responsibility to the hospital by which she is employed and the



responsibility on the hospital to check that?

HON. DR. ROSS: Well, another thing is

that the hospital has to supply that. I don't think that

you can just have a doctor say, "Look, I want three

private nurses put on this patient" without being

questioned. They are not the ones that are going to pay

for it.

THE CHAIRMAN: The hospital?

HON. DR. ROSS: Yes.

THE CHAIRMAN: In your interpretation

isn't necessary nursing services within the agreement

between the province and the Dominion?

HON. DR. ROSS: Is it necessary nursing

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THE CHAIRMAN: That is the language of

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3 hospital has the responsibility of providing necessary
4 nursing services under their agreement.

5 THE CHAIRMAN: If this happened often,
6 I think it might be felt in the deficits we were talking
7 about?

8 HON. DR. ROSS: This could be one area
9 where we would look at the end of the year if it happened
10 too often. I think, sir, that by my own experience with
11 medical staff that we have, I can only speak within our
12 own province, I think we have a group of medical personnel
13 who, on the whole, are responsible to the patients that
14 they serve, to the hospital they utilize and to the public
15 who have to pay the bill, and I think that this would be
a very small part of any problem in a hospital.

16 THE CHAIRMAN: Are you able to give me
17 or is someone with you, a ratio of nurses in the hospital,
18 I mean in terms of hours per patient? Do you operate on
some such ratio?

19 HON. DR. ROSS: Well, there are a lot
20 of figures put forward, sir.

21 THE CHAIRMAN: I mean, have you got a
22 formula in Alberta?

23 HON. DR. ROSS: I don't think we have.

24 MR. CAMPBELL: The answer to that would
25 be no, we don't use one. It has been brought out in our
26 discussions in regard to requirements and so forth, but
27 we haven't anything down as being staple. We have steered
28 away from the administration of the hospital. That is
the responsibility of the owners.

29 THE CHAIRMAN: In making up a rated -
30

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THE CHAIRMAN: In making up a ratio -



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3 this rated bed figure which you are giving in advance,
4 how do you calculate the amount that the hospital is
5 going to need for nursing?

6 MR. CAMPBELL: Would you care to take a
7 moment - in regard to this, what you are talking about
8 in regard to the ceiling, I think that is something
9 perhaps not fully understood. We started out our plan
10 with the idea when they weren't under government, when
11 they were paying their own way. Therefore we started out
12 with their basic cost in determining the ceiling at the
13 time the plan started. Then, each year this was built up
14 in regard to conditions which existed in that particular
15 year which were different from the conditions of the
16 previous year in determining the amount we would pay for
17 that particular year, so in this particular case you may
18 have had a situation in a given hospital where the nursing
19 ratio was very low. We provided in our scheme of applica-
20 tion of ceilings provisions for those that were very low
21 to increase more than those that were right up at the top,
22 with the result we left it open to them to pick up them-
23 selves. We have made exceptions. I don't believe Dr.
24 Ross would like to leave the indication that we had paid
25 no attention at all to this question of nursing services
26 and the relationship of nursing services to the services
27 which were being rendered in the hospital. We have, but
28 we haven't established any basic amount to say it should
29 be two nurses, two registered nurses for each patient, or
30 three, as the case may be. Dr. Ross has mentioned to you
he made a patient study in regard to the change in the
number of bodies recently in relationship to the number

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3 of patient days which showed a changing pattern here.
4 We have had pressures brought to bear on us from various
5 areas. These all brought us to the analysis of an agency
6 having standards which are applied in regard to their
7 particular hospitals.

8 THE CHAIRMAN: Thank you very much, Mr.
9 Campbell.

10 HON. DR. ROSS: I might add, sir, we
11 have just completed a three-year study of the number of
12 hospitals throughout the province so far as the staff
13 pattern was concerned. We hope to have the report
14 published soon that will show the variety of patterns
15 that exist throughout the hospitals in an attempt to
16 arrive at what might be a basic recommended pattern staff
we feel would be adequate.

17 THE CHAIRMAN: When that is available,
18 Doctor, when it is published...

19 HON. DR. ROSS: Yes.

20 THE CHAIRMAN: Could it be made available
to the Commission?

21 HON. DR. ROSS: Fine, we would be very
22 happy to, sir.

23 THE CHAIRMAN: Dr. Van Wart has some
24 questions.

25 COMMISSIONER VAN WART: The ceiling is
26 a very important thing in the administration of your
27 hospital plan. The setting of the ceiling price, in the
final analysis, rests with the Department; is that true?

28 HON. DR. ROSS: Yes, it is.

29 COMMISSIONER VAN WART: Has the hospital
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3 any right to appeal to anybody?

4 HON. DR. ROSS: They have the opportunity
5 to come in and discuss their particular, individual
6 situation with our Hospitals Division. There has recently
7 been representation made by a group to the Executive
8 Council on the problems of their hospitals.

9 They can come to my Director. They can
10 come to me, and if they wish to take it further they may
11 go to the Executive Council of our Government, which
12 really is the Legislature.

13 COMMISSIONER VAN WART: There is no sort
14 of Appeal Board in between you and the hospitals?

15 HON. DR. ROSS: We have, I think, a
16 relatively friendly relationship with the hospitals.

17 COMMISSIONER VAN WART: You have the
18 final...

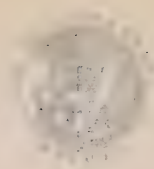
19 HON. DR. ROSS: That is right.

20 COMMISSIONER VAN WART: ...say or
21 control over them?

22 HON. DR. ROSS: Yes.

23 COMMISSIONER FIRESTONE: Mr. Chairman,
24 Minister, your brief contains a number of useful principles.
25 Perhaps we could develop them a little further, acquire a
26 little bit of additional understanding. Our Chairman
27 has been very helpful to the Commissioners in eliciting
28 information from you on these principles. If I may
29 follow in his footsteps, sir, would you say, sir, that
30 the Province of Alberta is in favour of the prepayment
principle for health services?

HON. DR. ROSS: Yes, I would say we are.



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I mean we have indicated the utilization of our prepaid health service plan and feel they are useful.

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COMMISSIONER FIRESTONE: I take it these principles would apply to hospital services because you already have it in operation?

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HON. DR. ROSS: This would apply to hospital services.

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COMMISSIONER FIRESTONE: In the field of hospitalization it already applies.

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HON. DR. ROSS: It applies?

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COMMISSIONER FIRESTONE: Prepayment.

HON. DR. ROSS: Prepayment applies in municipal taxation.

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COMMISSIONER FIRESTONE: But the principle has already been accepted that there is prepayment; in other words, the person that goes in the hospital doesn't pay for his services. It has been prepaid.

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HON. DR. ROSS: It has been prepaid in the majority of cases. Then, the additional costs that are involved in caring for an individual, he assumes that cost himself at the time.

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COMMISSIONER FIRESTONE: The \$1.50 or the \$2 you are referring to?

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HON. DR. ROSS: Yes sir.

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COMMISSIONER FIRESTONE: Would you apply the same principle to medical care services?

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HON. DR. ROSS: I think before any principle could be arrived at, Mr. Firestone, I think there would have to be very thorough discussions on what you are going to try and achieve and what amounts would be



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3 available for the development of such a service. We have
4 utilized individual payments as municipal tax payments.
5 We have used provincial revenue as provincial residents.
6 We have used Dominion subsidies as Canadian citizens. We
7 have used then the hospital patient - whether we use an
8 extension of that or a medical program or whether we
9 enacted a prepaid method utilizing voluntary agencies
10 prepared to give these services and subsidized the cost
11 of such programs where such subsidization was needed.
12 Not all the people need to be subsidized.

13 COMMISSIONER FIRESTONE: I understand,
14 Mr. Minister. I take it if satisfactory arrangements
15 could be worked out, satisfactory to the Province of
16 Alberta and to the people of Alberta as to the financing
17 you would be in favour, financing, administration, condi-
18 tions and terms and all other things you would be in
19 favour of the principle of prepayment of medical care
20 services.

21 HON. DR. ROSS: We feel that the prepaid
22 service has many factors in its favour, but always
23 qualifying it by the fact there are people who don't need
24 to be subsidized by prepayment.

25 COMMISSIONER FIRESTONE: That is under-
26 stood, Mr. Minister. I understand that. We will come to
27 that question of how we will pay for it in subsequent
28 questions. We are trying to establish in the beginning
29 the principle is sound, as I understand from you. Would
30 you believe in the same principle of prepaid dental care
service?

HON. DR. ROSS: I would say, yes.



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4 COMMISSIONER FIRESTONE: Thank you, Mr.
5 Minister. Would you apply the same principle, prepayment
6 of drugs, if some plan could be developed with safeguards
7 of misuse and is adequate and at the same time reasonable
8 and fair?

9 HON. DR. ROSS: With safeguards, yes.

10 COMMISSIONER FIRESTONE: You are then in
11 favour of the principle of prepaid drugs?

12 HON. DR. ROSS: The principle of prepay-
13 ment.

14 COMMISSIONER FIRESTONE: Thank you, Mr.
15 Minister. If I may go to paragraph 4 on page 2, you speak
16 of the principle underlying your public health program
17 and you say, and I quote:

18 "To subsidize essential health services
19 to the extent necessary to bring them
20 within the financial reach of our citi-
21 zens".

22 Does the term "subsidize" cover provin-
23 cial and federal contributions?

24 HON. DR. ROSS: That would be what I
25 indicated there.

26 COMMISSIONER FIRESTONE: That would be
27 your understanding, sir. Thank you. You have in the
28 Province of Ontario the federal-provincial hospital
29 program in operation now for several years. Would you
30 say, Mr. Minister, that subject to certain inadequacies
in the terms and arrangements and we come back to the
inadequacies, because you mentioned them, your experience
has been adequate and satisfactory.



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HON. DR. ROSS: The utilization of federal contributions to assist in the payment of the cost has been satisfactory.

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COMMISSIONER FIRESTONE: You would feel your provincial program, it is really a provincial program with federal contribution, has, on the whole, been a successful program.

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HON. DR. ROSS: I would say it has been, yes.

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COMMISSIONER FIRESTONE: And it has the full support of the citizens and the medical profession in the province?

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HON. DR. ROSS: I would say it has, Mr. Firestone, yes.

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COMMISSIONER FIRESTONE: Thank you very much, Mr. Minister. To come to some of these inadequacies to which you refer and particularly in paragraph 8 you say and I quote, in your opinion, and the quote begins here:

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"A gross injustice and imposes an additional financial burden on the Alberta provincial treasury".

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I take it this gross injustice results from the fact that the Federal Government refuses to recognize funds paid by the Alberta citizens, that is the \$1.50 and the \$2.

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HON. DR. ROSS: Co-insurance.

COMMISSIONER FIRESTONE: The co-insurance principle. Has the Federal Government given you reasons why they refuse to accept this?



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4 HON. DR. ROSS: Mr. Chairman, members
5 of the Commission, the Hospital Services and Diagnostic
6 Act of the Federal Government has definitions and one of
7 the definitions is authorized charges and they don't
8 share in authorized charges which are services which the
9 patient pays on utilizing the hospital service, and they
10 have merely stayed in the letter of the law and said that
11 since this co-insurance, since it is paid by the patient
12 when he utilizes hospital services it becomes an authorized
13 charge and under the Act they couldn't share in it.

14 Now, we have on many occasions attempted
15 to get them to recognize that this is a part of the opera-
16 tional cost of hospitals in Alberta, but they just say no.

17 Now, in their overall national averaging
18 they utilize 25%, I believe I am right in that, of the
19 co-insurance into their formula. But this non-recognition,
20 the non-recognition of the patient's contribution towards
21 operation costs of hospitals is costing us a matter of
22 several million dollars a year -- a million-and-a-half,
23 something like that. A million, two hundred and fifty.

24 This is deducted from the shareable
25 cost. In other words, you get the gross operational cost
26 of our hospital service and then you deduct the offset
27 revenue of non-eligible patients: the D.V.A., the Work-
28 men's Compensation Board, and co-insurance. All of those
29 things come off to get your shareable amount.

30 COMMISSIONER FIRESTONE: You explained
in an answer you gave that the legislation as it now
reads does not permit them, the way they interpret it, to
make that contribution. That may be a formal answer, but



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3 is there a basic economic financial administrative reason
4 behind this attitude so that one can come to grips with
5 the problem, because laws are made for man and man can
6 change laws, I presume?

7 HON. DR. ROSS: I would have hoped so.

8 COMMISSIONER FIRESTONE: So I would
9 therefore come to this, that the question should be re-
10 stated to mean are there any reasons behind that attitude
11 that has been taken by the Federal Government, and have
12 these reasons been communicated to you, and if not that
is fine, but would you let us know, please?

13 HON. DR. ROSS: We have attempted to
14 find out and we have approached them on many levels and
15 on many occasions with this particular problem, because
16 we have felt it is an injustice to the people of Alberta.
17 And we have merely been quoted the Act. I have suggested
18 amendments to the Act that they could very easily put in,
19 and I suggested to the Minister this was a wonderful year
to bring his Act into the House.

20 THE CHAIRMAN: For Alberta, Mr. Minister?

21 HON. DR. ROSS: No, for the Federal
22 Government.

23 COMMISSIONER FIRESTONE: You see, sir,
24 this Royal Commission is charged with the task of offering
25 advice to the Federal Government of any changes in policy
26 or legislative changes. Perhaps it would help us if you
27 could put to us, at some subsequent occasion if necessary,
28 the amendment you have proposed and elaborate some of the
reasons for it.

29 HON. DR. ROSS: May I say this, sir, and
30



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HON. J. ROSS: May I say this, sir, and



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3 I do not say it unfairly, but being a Minister I am depen-
4 dent upon all these people that I have here and others to
5 bring recommendations for amendments to the various
6 statutes that I am responsible for.

7 There may be an occasional time when I
8 will ask to have an amendment made myself, because it has
9 come to my attention, and I will discuss it with them.
10 But, on the whole, Ministers of the Crown are dependent
11 upon the people in their Departments to bring forward
12 amendments to legislation. And I have indicated to the
13 people in the Hospitals Division down there that I have
14 no hope of seeing this iniquity corrected unless they will
15 bring forward the suggested amendment to their Minister
and tell their Minister.

16 Now, why they will not -- I can only say
17 some of them feel that a patient should not have to pay
18 a bill when they go in and get sick. I asked them if the
19 businessman does not have to pay his instalment on his
radio or TV set when he is sick. I think he does.

20 In other words, that the service, that
21 the goods that they purchase, they have to pay for whether
22 they are well or sick. With the way our hospitalization
23 program is being developed, it does not deny them the
24 right to get hospital services when they need them, but it
25 requires payment for them when they use them. I can only
26 say I feel there are certain attitudes that may be present
27 in some of the people. They feel that this is not a good
28 thing to do, to charge people when they are sick. And,
they are not prepared to do it.

29 COMMISSIONER FIRESTONE: I take it this
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4 may be an opportunity for you to put your view to the
5 Canadian Government in a different sort of way, and
6 perhaps if this Commission has the opportunity to consider
7 the merits of your proposal it might help the cause of
8 improving your position, and it could, therefore, at a
9 subsequent time receive from you the proposed legislative
change and the reasons for it in detail.

10 HON. DR. ROSS: We had suggested that
11 perhaps a slight amendment would say that it does not
12 include sums for capital purposes.

13 COMMISSIONER FIRESTONE: I was not trying
14 to get the answer right now, realizing there are some
15 legal questions involved.

16 HON. DR. ROSS: I would be happy to
17 submit that. I will ask Mr. Campbell to make a note of
18 it, and we will write to the Commission.

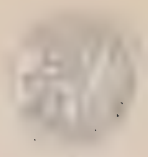
19 COMMISSIONER FIRESTONE: Would there be
20 other aspects of the hospital program as far as federal-
21 provincial relations are concerned that could stand
22 improvement, and if so, could that letter which would be
23 sent to us include additional proposals that you may have
in mind, both of an administrative nature and of a policy
nature?

24 HON. DR. ROSS: Yes, sir, we would be
25 happy to do that.

26 THE CHAIRMAN: I suppose that would be
27 a development of your paragraph 148?

28 MR. FRAWLEY: I was wondering how soon
29 you were going to see that.

30 THE CHAIRMAN: I saw it long ago, Mr.



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3 Frawley.

4 HON. DR. ROSS: Well, it would be part
5 of them, Mr. Chairman. I would feel that I would have to
6 again raise the question I have discussed with the Federal
7 Government on a number of occasions soon after the initia-
8 tion of the program of some way in which the Federal
9 treasury, through its Bank of Canada, could make available
10 sources of social capital for hospital construction
11 purposes at low interest rates. I think that this is not
12 perhaps -- and I indicated at the time we did not feel it
13 was as needed here as I am sure it must be in other areas
14 of our Dominion -- but this is a need that I think has to
15 be met some way to lift the financial burden for the
16 people who are now trying to raise money to build hospitals
17 to serve the needs of the people. It is a social work and
18 it is different from our risk capital of business where a
19 profit motive is there.

20 COMMISSIONER FIRESTONE: Thank you for
21 your willingness to supply us with this additional infor-
22 mation requested, and may I add one more request and beg
23 your indulgence.

24 I take it you may have some views about
25 the working of the federal-provincial health grant system
26 in general, and you may feel some improvements are indi-
27 cated in that system as well.

28 Would it be possible to add to this
29 letter, which is getting longer by the minute, your
30 comments on possible improvement in that field as well?

31 HON. DR. ROSS: I am sure my Deputy and
32 my Assistant Deputy would be very happy to collaborate in



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3 some comments there, because it has given me a great deal
4 of concern: the amount of administrative cost that is
5 involved; in some of the monies that are involved.

6 THE CHAIRMAN: You are also concerned
7 with the fact that they are conditional: you get X dollars
8 provided you spend Y dollars?

9 HON. DR. ROSS: That is right. This is
10 something that we feel can be unfair to the provinces
11 who cannot supply the matching amounts. We have been
12 fortunate here in that we have been able to, but you get
13 caught in programs that politically you cannot leave alone,
and then you are left out on the end of the limb later on.

2 14 COMMISSIONER FIRESTONE: That is very
15 helpful. May I now turn to paragraph 10-1 on page 3 of
16 your summary, and I quote:

17 "The aggregate cost is more rather than
18 less when the State is injected between
19 the citizens receiving the service on
20 the one hand and paying the bill as
21 taxpayers on the other".

22 Could you elaborate as to why you make
23 this statement and this is based on experience in the
Province of Alberta?

24 HON. DR. ROSS: I think that any time
25 you are developing the Departments of government and
26 developing the administrative costs of those, as Professor
27 Parkinson has shown does occur, there is going to be an
28 additional cost and an increase in the aggregate cost
29 above what it would have cost had you utilized a different
30 form of achieving those services.



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4 We feel that in our patient or medical
5 services that we have achieved this by simple agreement
6 with the College of Physicians and Surgeons, with the
7 Alberta Dental Society, with the Optometric Association,
8 with the Chiropractic Association, where we have provided
9 certain per capita amounts under an agreement to these
10 professional groups for the provision of services to a
11 select group of people of the province. The cost of
12 administration through government through such an arrange-
13 ment, I think, is fairly substantial. It would be hard
14 to pull it out and put it in dollars and cents, but I
15 think they develop the programs within government to
16 provide certain things: you realize the increasing costs
17 that are involved there.

18 COMMISSIONER FIRESTONE: I take it that
19 even though you are making financial contribution to
20 private non-profit operations to administer certain plans
21 or schemes or program, you still supervise the spending of
22 the money and whether it is spent for the purpose desig-
23 nated.

24 Is there no accounting given as to what
25 has happened to the money?

26 HON. DR. ROSS: We enter into an agreement
27 to pay them certain sums of money and to purchase certain
28 service. We know how much we have given them. We some-
29 times have direct communication from some of the people
30 who are supposedly receiving the service which we might
draw to the attention of the professional group supplying
it. It is merely a question. But we do not direct -- in
our agreement we ask that certain services be provided,



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3 and we leave it up to that professional group to provide
4 this, to discipline their members in the administration
5 of this, and to administer the funds for them.

6 COMMISSIONER FIRESTONE: If I may come
7 back again to this question of control, sir. You will
8 recall the Chairman raised some questions on this subject
9 of State control. If I may develop this a little bit
10 further, sir.

11 The question arose whether the extension
12 of the principles which you have applied in the hospital
13 program to a medical care program would involve control
14 over physicians, and if I understood your answer correctly,
15 sir, you were saying that this may affect control within
16 groups affected. If my understanding was not quite
17 correct, perhaps you would care to restate your answer to
18 the Chairman so that I can follow it, too.

19 HON. DR. ROSS: I think that the control
20 of the quality and quantity of service has to be maintained
21 by the group providing it. I think that way, entering
22 into an agreement with such a group must indicate the
23 quantity that we desire.

24 COMMISSIONER FIRESTONE: Yes.

25 HON. DR. ROSS: The quality is dependent
26 entirely upon the type of people that are in that profes-
27 sional group; that we hope our provincial Acts relating
28 to it have helped to secure it.

29 COMMISSIONER FIRESTONE: I take it when
30 we speak of control we are referring to control over the
money that will be paid, say, to physicians to provide
medical care services rather than control over physicians



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3 as to how they provide that medical care; is that correct?

4 HON. DR. ROSS: The control of the money
5 -- it is provided to give the service.

6 COMMISSIONER FIRESTONE: To pay to the
7 physician to provide the service?

8 HON. DR. ROSS: Yes, to give the service.

9 COMMISSIONER FIRESTONE: Let us assume,
10 for discussion's sake, that you estimate that a medical
11 care service program for the Province of Alberta on a
12 comprehensive basis would cost, say, \$20,000,000 for the
13 first year of operations, and you enter an agreement with
14 the medical profession or any organization representing
15 them to provide that service. Let us say that after the
16 end of the year you discover that the estimates were a
17 little on the low side, and this happens, and it may cost
18 you \$22,000,000. What happens in that case? Does that
19 mean that the doctors would have to take 10% less of their
20 fees, or does it mean that the Government of Alberta will
21 try to raise, say, half of that deficit and come to present
22 the bill to the Federal Government for the other half,
23 assuming there is 50-50% share agreement? I am just
24 trying to establish what this control over money means
25 for the doctors.

26 HON. DR. ROSS: Well, I think, sir, that
27 our experience with our agreements with several profes-
28 sional associations over the past 14 years gives some
29 indication of how this comes about, and there was mutual
30 discussion with the executive bodies of these groups
with the Department of Health that arrived at what the
Government wanted in the way of quantity of services.



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3 Quality depends on the status of the men in those profes-
4 sions.

5 COMMISSIONER FIRESTONE: Yes.

6 HON. DR. ROSS: And then we came to the
7 decision as to how much per capita would this amount to.

8 In the early years, this was, I believe,
9 \$10 to \$12 per capita. This was the agreement reached
10 between the College of Physicians and Surgeons and the
11 Department of Health for provision of service -- all
12 medical calls, home calls, office calls, hospital care,
13 surgery, diagnostic work in the laboratories -- to these
14 pensioners, when the pensioner called upon the doctor for
15 the service. The patient-doctor relationship was not
16 disturbed. And over the years this has increased and is
17 now \$24. The last agreement I signed with the College
18 was \$24 per capita, and it is my understanding that this
19 amount of money after the administrative costs, which are
20 really quite small, are deducted, provides about 62%, I
21 think, in final settlement of the minimum schedule of
22 fees set by the College: about 62% of the minimum schedule
23 of fees for services rendered.

24 Now, over the years it has been around --
25 I think it has varied between 45% to about 60%.

26 The doctors have recognized their moral
27 obligation in this low income group to make some contribu-
28 tion to the cost of provision of these services, and there
29 are few doctors who are worthy of being called doctors
30 who have not recognized this responsibility.

31 So that there have been over these years,
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Now, over the years it has been around -- I think it has varied between 4% to about 6%.

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So that there have been over these years, though, the agreements run for two years -- two or three



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years -- and we have these agreements signed with a
cancellation clause, and that is that one party may come
in and want to enter into re-arrangements for agreement,
but with this, as I say, \$10 in 1947; \$12.50 in 1948 --
the services were increased.

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And, then, there was a little money
added for overhead purposes in 1950: \$15 in 1950; \$16.50
in 1951. These amounts, and \$24 in these last two or
three years.

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So that there has been agreements and
mutual discussion. In our province, it has been our
attempt, whether it is in the field of health or any
other area, to be prepared to sit down and discuss with
the groups we are doing business with to the mutual
satisfaction of each.

McH/dpw

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COMMISSIONER FIRESTONE: May I take it
from what you say that this was a sound principle in this
case of low income earners but I presume if there were a
scheme introduced applicable to all people of Alberta
such a scheme would not wish to have the doctors subsi-
dize the program; they would get paid, so to speak, their
considered reasonable fee schedule. One can see a case
being made in the case of low income people that this
would follow a somewhat different principle and the
doctors ought to be paid for the sort of services they
are rendering to the people of Alberta. Would you accept
that as a principle, low income groups accepted?

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HON. DR. ROSS: I think this is a
question that the organized medicine should answer. As
a member of the profession I would say this - this is



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3 only as an individual member of that profession - that I
4 think there is still a place when there is total coverage
5 of the cost of services that some recognition could be
6 made from the 100% of the minimum schedule of fees. This
7 is done today under the Workmen's Compensation Act, with
8 our cancer services, with other areas and I think it
9 should be recognized.

10 COMMISSIONER FIRESTONE: It is a very
11 good point. You can make the case that the future doctor
12 would have no collection problems and other administrative
13 problems and he would save himself money and perhaps 90%
14 or some percentage accepted and reasonable to the medical
15 profession might be the basis. Let us assume this is
16 accepted. A schedule has been worked out satisfactory to
17 the Province of Alberta and to the profession; notwith-
18 standing that a deficit develops at the end of the year
19 because the estimates were too low. What happens then?

20 HON. DR. ROSS: I think we should be
21 prepared to enter into discussion with these people to
22 see how that deficit could be made up provided we were
23 satisfied that there was no misuse or other provision
24 of services that had brought about this deficit. We are
25 responsible to the people of Canada in protecting the
26 money they make available.

27 COMMISSIONER FIRESTONE: I take it if
28 the medical profession was to have some discussions and
29 say "We have revised our schedule from 100¢ on the dollar
30 to 80¢ or 95¢ but we want to get this" that this something
might be considered reasonable provided you are sure there
is no misuse or other utilization.



only as an individual member of that profession - that I think there is still a place when there is total coverage of the cost of services that some recognition could be made from the 100% of the minimum schedule of fees. This is done today under the Workmen's Compensation Act, with our cancer services, with other areas and I think it should be recognized.

COMMISSIONER FIRSTONE: It is a very good point. You can make the case that the future doctor would have no collection problems and other administrative problems and he would save himself money and perhaps 30% on some percentage accepted and reasonable to the medical profession might be the basis. Let us assume this is accepted. A schedule has been worked out satisfactory to the Province of Alberta and to the profession; notwithstanding that a deficit develops at the end of the year because the estimates were too low. What happens then?

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HON. DR. ROSS: That is right.

COMMISSIONER McCUTCHEON: May I say what you are saying; it would not differ essentially from what you said about the hospital plan that you pay the money and you call the tune.

HON. DR. ROSS: I think this is basically the responsibility of government, yes. I know, Commissioner Firestone, you are saying I am not saying the same thing here but I am. Government have a basic responsibility to the people they serve and the amounts of money they are spending in purchasing for a service, if they are convinced that the amount that they set aside for purchasing those services is inadequate then I think they have a responsibility to discuss and make sure that the services have been legitimately provided and pay the cost.

COMMISSIONER FIRESTONE: Please interrupt me if I am wrong but you were talking in connection with the people in low income brackets and you work out an arrangement and pay for the material and say "Do the job well boys". The same principle would apply to a comprehensive medical care scheme and you would have the same sort of control you have now over the hospital program in the Province of Alberta.

HON. DR. ROSS: I would hope that perhaps Mr. McCutcheon would give me a leading question there.

COMMISSIONER McCUTCHEON: I could do that very easily.

HON. DR. ROSS: I feel the professional group should be capable of administering their own programs without interference. When you have arranged the necessary



HON. DR. ROSS: That is right.

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3 amount to provide those, as Mr. McCutcheon said, you pay
4 the money and you call the shot. If you mean we would
5 interfere with the provision of services purchased from
6 professional groups, I would say no, we are not going to
7 be interfering with professional groups. We believe these
8 people are capable but we also have the responsibility.
9 We have had very excellent relationships here in discus-
10 sing things with one or the other of the professions and
11 government and I do not think we would have any problems.

12 COMMISSIONER McCUTCHEON: In dealing with
13 a very enlightened government I am sure that would be true,
14 once you have entered into this agreement with the profes-
15 sion to provide comprehensive medical care for all of the
16 people of Alberta. I suggest if you do that it will
17 be difficult to have the profession render care at one
18 level to one group and at another level to a different
19 group but you will agree with an average discount from
20 the fee basis and I suggest to you the only way that fee
21 basis will ever be increased is if the Government of
22 Alberta agrees to it. I do not object to it but I suggest
23 that is a fact.

24 HON. DR. ROSS: I think the Government
25 has given evidence that it recognizes that the cost of
26 service can increase; it has in the hospitalization
27 services, it has in the professional services. We have
28 recognized that the increase in schedules of fees may be
29 brought about, increased demand for per capita amounts,
30 we have agreed upon that. I would feel if there was
increased cost of providing the services that they should
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3 "Well, it will only come about if the province agrees to
4 it". Yes, I suppose you are spending the money, you have
5 to agree to this and these are brought about really by
6 statutory agreement, at least by statute in the legisla-
7 tion. Our Treatment Services Act has promised us to
8 enter into an agreement and pay certain amounts of money
9 so this eventually comes back to the people who are repre-
10 senting the people of the particular area.

11 COMMISSIONER McCUTCHEON: I am not objec-
12 ting to the position you are taking or necessarily agreeing
13 with it. I think you answered my question, the fact is
14 that would be the way it would be finally settled.

15 HON. DR. ROSS: Mutual agreement.

16 THE CHAIRMAN: On such a note we will
17 adjourn for lunch and reconvene at 2 o'clock.

18 --- Luncheon adjournment.
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that would be the way it would be finally settled.
HON. MR. FORD: Mutual agreement.
THE CHAIRMAN: On such a note we will
adjourn for lunch and reconvene at 2 o'clock.

--- Session adjournment.



B/dpw

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4 --- On resuming at 2 p.m.

5 THE CHAIRMAN: Mr. Firestone.

6 COMMISSIONER FIRESTONE: Mr. Chairman,
7 Minister, in coming to the final part of my questioning,
8 I wonder whether we could deal with some of the aspects
9 of a possible comprehensive medical care program that
10 may be acceptable to the Government of the Province of
11 Alberta and the people of the Province of Alberta. I
12 would like to start out by referring to one of your key
13 paragraphs in paragraph 10 on page 4 in which you lay
14 down as a principle the Government of Alberta believes,
15 and now I quote:

16 "That only by maintaining a system in
17 which private enterprise and individual
18 initiative and personal responsibility
19 combined with whatever financial subsi-
20 dization is required from society
21 collectively can the best interest of
22 our people in the field of health be
23 successfully and adequately served".

24 Now, sir, I take it this paragraph would
25 apply to medical care service programs if one were
26 developed in the Province of Alberta?

27 HON. DR. ROSS: That is correct.

28 COMMISSIONER FIRESTONE: Would you say,
29 sir, that this would include a comprehensive medical care
30 program?

HON. DR. ROSS: At the present time the
medical service program in Alberta is a comprehensive one.

COMMISSIONER FIRESTONE: Therefore

Minister, in coming to the final part of my questioning, I wonder whether we could deal with some of the aspects of a possible comprehensive medical care program that may be acceptable to the Government of the Province of Alberta and the people of the Province of Alberta. I would like to start out by referring to one of your paragraphs in paragraph 10 on page 4 in which you lay down as a principle the Government of Alberta believes, and now I quote:

"That only by maintaining a system in which private enterprises and individuals initiative and personal responsibility combined with whatever financial support is required from society collectively can the best interest of our people in the field of health be successfully and adequately served."

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COMMISSIONER FURSTON: Would you say, sir, that this would include a comprehensive medical care program?

HON. DR. ROSS: At the present time the medical service program in Alberta is a comprehensive one.

COMMISSIONER FURSTON: Therefore



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3 comprehensiveness is part of the essential features of
4 the program?

5 HON. DR. ROSS: And the needs of the
6 people.

7 COMMISSIONER FIRESTONE: Thank you, Mr.
8 Minister. This program would be available, this program
9 would make available basic medical care services to
10 every citizen in the Province of Alberta irrespective of
11 age, occupation, location, etc.?

12 HON. DR. ROSS: That is correct.

13 COMMISSIONER FIRESTONE: Thank you, sir.

14 HON. DR. ROSS: It does today.

15 COMMISSIONER FIRESTONE: If the Province
16 of Alberta had a choice of developing such a program on a
17 voluntary basis or a compulsory basis what would be your
18 choice?

19 HON. DR. ROSS: Voluntary.

20 COMMISSIONER FIRESTONE: It would be a
21 voluntary program.

22 HON. DR. ROSS: If not, compulsory.

23 COMMISSIONER FIRESTONE: If you had a
24 voluntary program, we have to consider then, of course,
25 as well as in a compulsory one, the question of financing.
26 As I understand it you are in favour of the principle that
27 those who can afford to pay for such medical care services,
28 those people would do so either through taxes, through
29 premiums or other means, or a combination of all those,
30 and those that couldn't afford to pay, either in full or
in part, have their payments made by the State in accor-
dance with the principle in your paragraph 4 which says

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dance with the principle in your paragraph 4 which says



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4 you feel it necessary to subsidize essential health
5 services to the extent necessary to bring them within the
6 financial reach of your citizens.

7 HON. DR. ROSS: That is correct.

8 COMMISSIONER FIRESTONE: Now, let us
9 assume that you are trying to introduce such a program
10 in the Province of Alberta. You would need an administra-
11 tive carrier to implement it. You need an organization
12 to implement it. Would you consider the Alberta Medical
13 Service as such a carrier, let us call it a designated
14 carrier?

15 HON. DR. ROSS: I would feel it would be
16 a very suitable carrier, yes.

17 COMMISSIONER FIRESTONE: Thank you.

18 THE CHAIRMAN: One of a number?

19 HON. DR. ROSS: One of the number?

20 THE CHAIRMAN: Yes.

21 HON. DR. ROSS: It is a non-profit
22 organization selling services its members have to sell,
23 and we feel that it is a most likely and most suitable
24 type to use.

25 MR. FRAWLEY: M.S.I., you mean? You
26 said Alberta Medical Services.

27 COMMISSIONER FIRESTONE: Medical Services
28 Incorporated of Alberta.

29 MR. FRAWLEY: I think it is just Medical
30 Services Incorporated.

COMMISSIONER FIRESTONE: Operating in
Alberta.

HON. DR. ROSS: I think we interpret it



you feel it necessary to subsidize essential health services to the extent necessary to bring them within the financial reach of your citizens.

HON. DR. ROSS: That is correct.

COMMISSIONER FIRESTONE: Now, let us

assume that you are trying to introduce such a program in the Province of Alberta. You would need an administrative carrier to implement it. You need an organization to implement it. Would you consider the Alberta Medical Service as such a carrier, let us call it a designated

HON. DR. ROSS: I would feel it would be

a very suitable carrier, yes.

THE CHAIRMAN: One of a number

HON. DR. ROSS: One of the numbers

THE CHAIRMAN: Yes.

HON. DR. ROSS: It is a non-profit

organization selling services its members have to sell.

and we feel that it is a most likely and most suitable

type to use.

said Alberta Medical Services.

COMMISSIONER FIRESTONE: Medical Services

Incorporated of Alberta

MR. FRAWLEY: I think it is just medical

Services Incorporated.

HON. DR. ROSS: I think we interpret it



1
2
3 the same.

4 COMMISSIONER FIRESTONE: I take it this
5 would be a designated carrier and it wouldn't necessarily
6 preclude other commercial carriers providing additional
7 services if the public so desires. Is that your view,
8 sir?

9 THE CHAIRMAN: Commercial carriers?

10 HON. DR. ROSS: I realize what he is
11 asking, if a profit method with commercial carriers would
12 be used. They would be purchasing services from another
13 group to sell their customers.

14 COMMISSIONER McCUTCHEON: They might be
15 so efficient they could still make a profit and compete
16 with M.S.I.

17 HON. DR. ROSS: It is only, Mr. Chairman,
18 you would have an agreement between the people who are
19 providing the services and the carrier; in other words,
20 if they were prepared to have a carrier sell their services.

21 COMMISSIONER FIRESTONE: If you had a
22 provincial plan I presume your designated carrier would
23 be a non-profit carrier?

24 HON. DR. ROSS: In preference to a profit
25 carrier.

26 COMMISSIONER FIRESTONE: On different
27 principles. Now, Mr. Minister, I take it if such a plan
28 were to develop you would feel that the Federal Government
29 should make a contribution to such a comprehensive medical
30 care service plan in the Province of Alberta, financial
contribution, that is.

HON. DR. ROSS: Since they have initiated



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3 the discussion and the study of a comprehensive medical
4 program through your Commission I would feel if it is
5 felt to be desirable for the people of Canada therefore
6 the Federal Government should make a contribution to the
7 provinces to carry out the responsibility that is theirs
8 and that they have asked them to do.

9 COMMISSIONER FIRESTONE: We have come
10 across in the various provinces different suggestions.
11 Some felt the Federal Government should contribute 50%,
12 another province thought 60%. Have you any views as to
13 the extent of such a contribution?

14 HON. DR. ROSS: I would think before any
15 progress could be made at all in coming to any definite
16 solution of this there would have to be a very thoughtful
17 and lengthy discussion between the federal and provincial
18 people involved in this to try and work out what is
19 considered to be in the best interest from the point of
20 view of the government concerned as to how this could be
21 done. I don't think it would be proper at all for me to
22 say what I think should be done without sharing my
23 thoughts with the thoughts of other people across Canada
24 to try and work out what might be considered to be the
25 best solution. This would have to involve the people who
26 are providing the service. I feel it would be improper
27 for me to say what I think should be done. My only
28 feeling is this: that there is today a very large part
29 of our people covered in Alberta with prepaid types of
30 programs, whether they are M.S.I. or commercial insurance
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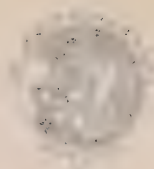
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3 The doctors carry a certain share of the coverage by
4 uncollected accounts. They still get the service, and
5 I am convinced that the people of Alberta and the people
6 of Canada get one of the highest quality of medical care
7 of any place in the world whether they can pay for it or
8 not, and that the moral responsibility of the professions
9 to supply this must remain, and I believe that the need
10 for some comprehensive provision of professional medical
11 service, dental service or drug service is not nearly as
12 required through individual patients to individual profes-
13 sional personnel as is the need for many of the things
14 that only society collectively can provide for its people.

15 For that reason I think there are other
16 needs we must look at before we go into the area that at
17 the present time is being met reasonably well under the
18 present circumstances and can be met in the other areas
19 that need to be met without there being an overall compre-
20 hensive compulsory type of program.

21 THE CHAIRMAN: Dr. Ross, assuming that
22 there are X dollars available for these services which
23 is not sufficient to cover the whole field, have you any
24 views to offer as to the areas of priority in terms of
25 the money available, whether it is physicians' services
26 or mental health or tuberculosis or retarded children or
27 psychiatric care in this country.

28 HON. DR. ROSS: Well, probably a biased
29 opinion, sir.

30 THE CHAIRMAN: Well, I mean a biased
opinion that is founded on some conviction is a good
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4 HON. DR. ROSS: Well, I have certain
5 convictions, sir, and I realize these are based only on
6 a short term in public office and a reasonably lengthy
7 term in private practice that makes me believe that some
8 of the things that are being talked about on individual
9 patient-doctor service are being supplied today quite
10 adequately, and can be met by the individual with the
11 individual professional person, but that individuals
12 cannot meet certain other needs society collectively
13 must meet. These are certainly in the field of mental
14 health where there is still a need for a greatly
15 increased number of qualified people in the social worker
16 field, the psychiatric nurses, the psychologists, the
17 psychiatrists, the physical facilities that have to be
18 expanded with the continuing need.

19 We have been fortunate here in having
20 been able to continue with the building program that has
21 reduced the overcrowding that had existed here in the
22 past and exists across Canada today. There is a need to
23 extend these mental health facilities that I think have
24 to be subsidized out into the regional areas of our
25 province, and we are attempting to establish regional
26 cost systems where we can make the facilities in certain
27 areas or regions more capable of handling the needs of the
28 region. In some of these areas we have to have out-
29 patient services, psychiatric out-patient services.
30 Perhaps the subsidy of the salary of private psychiatrists
in that area, beds available in the regional hospitals
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3 care and if it is required out into the longer term active
4 care hospitals. The need for an increased number of
5 preventive mental health services throughout our province
6 that we have attempted to meet in clinics, as you will
7 see in our brief; this need, I think, has to be expanded.
8 Some of the long-term illnesses that require a considerable
9 amount of professional skills in a hospital setting and
10 facilities of rehabilitation - the individual cannot meet
11 out of his own pocket. They have to be subsidized. Some
12 of the types of illnesses today that are at least being
13 kept from progression. They are not curable, but they
14 are treatable, treatable with drugs that are very expen-
15 sive. An attempt of an individual to try and meet those
16 costs is prohibitive. I think here again a subsidization
17 program like we have a special drug program in our Depart-
18 ment under Dr. Robins and we have considered an expansion
19 of that into some of these areas of corticoids. There are
20 many problems related to it but I don't think it makes it
21 good government service. I think there has to be some
22 subsidization of the cost of this type of service to meet
23 the needs of the people.

22 COMMISSIONER McCUTCHEON: You would subsi-
23 dize a voluntary organization to assist in that?

24 HON. DR. ROSS: No, I think, Mr. McCutcheon,
25 in terms of assisting in the provision of the cost of
26 these drugs that are administered under the private doctor.
27 I mean, this talk of high cost of medical care is not just
28 the payment of the doctors' fee. It is grouped together
29 into hospitalization, drugs that they get as patients out
30 of the doctors' offices or on an out-patient basis.

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3 The total cost of professional medical services is only
4 a part of this cost of what is called medical care and
5 certain areas of this medical care we have met. In some
6 areas we have met the cost of some of the drugs. There
7 are other areas in the drug area that I think have to be
8 met in some manner or other, not necessarily by a compre-
9 hensive program that pays for aspirin tablets.

10 THE CHAIRMAN: Dr. Ross, suppose the
11 Province of Alberta, any province received a grant of
12 ten million dollars, say, in round figures, from the
13 Federal Government, would you use that money to pay physi-
14 cians' services or for something else that you might
think had a higher priority.

15 HON. DR. ROSS: No strings attached, I
16 would use it for the things I think we have to get done
17 for the people of Alberta.

18 THE CHAIRMAN: These things being what?

19 HON. DR. ROSS: This wouldn't include a
20 comprehensive physician, dentist, drug service for every-
body.

21 COMMISSIONER McCUTCHEON: You haven't,
22 Dr. Ross, met a person who has not been receiving medical
23 service in Alberta because he couldn't afford to pay for
24 it?

25 HON. DR. ROSS: I haven't.

26 COMMISSIONER FIRESTONE: Mr. Minister,
27 you were very helpful in suggesting a little earlier that
28 before the Province of Alberta could embark on a comprehen-
29 sive medical program you would want to consult, have
30 consultations within the Province of Alberta, the medical



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3 profession and others, and you would want to consult with
4 other provincial governments in developing what is a
5 reasonable program.

JO/dpw 6 I can understand that. We accept that,
7 but you realize that this Royal Commission is called upon
8 to offer some advice to the Federal Government, and in
9 offering that advice we are very anxious to obtain the
10 views of the various provincial governments. So that, in
11 putting forward some proposal to the Federal Government
12 account of these views has been taken, so please feel free
13 in this way, that in dealing with the question I put
14 before you you are not in any way committing the Government
15 of Alberta to any particular cause; you are just helping
16 us to understand what are your basic thoughts on these
17 subjects so that we can take them into account as and when
18 we submit recommendations to the Federal Government. So,
19 therefore, my questions are all trying to learn more of
20 your thinking and that of the people of Alberta.

21 HON. DR. ROSS: Yes.

22 COMMISSIONER FIRESTONE: Now, sir, on
23 this point, as a Minister of Public Health, you are
24 familiar with health conditions in the Province of Alberta.
25 And, as a Cabinet Minister, you are familiar with the
26 wishes of the people in the Province of Alberta. Would
27 you say, sir, that there is popular demand for a comprehen-
28 sive medical care program in Alberta on a voluntary basis?

29 HON. DR. ROSS: If that were to be judged
30 by the representations that have been made to me or by the
letters received by me, I would say that there is no
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profession and others, and you would want to consult with other provincial governments in developing what is a

I am understanding that. We accept that, but you realize that this Royal Commission is called upon to offer some advice to the federal government, and in offering that advice we are very anxious to obtain the views of the various provincial governments. So that, in putting forward some proposal to the federal government account of these views has been taken, so please feel free in this way, that in dealing with the question I put before you you are not in any way committing the Government of Alberta to any particular course; you are just helping us to understand what are your basic thoughts on these subjects so that we can take them into account in and when we submit recommendations to the federal government. So, therefore, my question is all, trying to learn more of your thinking and that of the people of Alberta.

HON. DR. ROSS: Yes.

COMMISSIONER: Now, sir, on

at this point, as a Minister of Public Health, you are familiar with health conditions in the Province of Alberta, and, as a Cabinet Minister, you are familiar with the wishes of the people in the Province of Alberta. Would you say, sir, that there is popular demand for a comprehensive medical care program in Alberta on a voluntary basis?

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3 you with that impression. I think that the public are
4 often very -- they are oftentimes not vocal in putting
5 forward many of their ideas, and it is only by discussing
6 it at local levels and in small groups that you can begin
7 to assess this type of attitude. I would think, however,
8 that people, being human beings, that if they felt there
9 was some way they were going to get a program that was
10 going to provide them with something without costing them
too much, they would want it.

11 COMMISSIONER FIRESTONE: And particularly
12 if the principle you have outlined, sir, is implemented
13 and that principle is that those who cannot afford to pay
14 the full share of the cost or not at all, and it may not
15 be covered by different programs in existence at the
16 moment, they would stand to benefit?

17 HON. DR. ROSS: They would stand to bene-
18 fit.

19 COMMISSIONER FIRESTONE: And, as you know,
20 there are many classes not eligible for insurance coverage
21 either by age or pre-existing conditions. And, still,
22 there are people who may have an adequate income to pay
23 a \$5 fee to a doctor but might find it very difficult if
24 they are hit by emergencies or by protracted illness to
25 pay these bills. So there are areas where this would
26 meet a definite need. Will you agree with that?

27 HON. DR. ROSS: I would agree there are
28 certain types of programs that could be developed by the
29 prepaid agencies that would take care of financial catas-
30 trophes for medical health care that would be appreciated
by the people generally. And they would no doubt be very

you with that impression. I think that the public are often very -- they are often times not vocal in putting forward many of their ideas, and it is only by discussing to some extent this type of attitude. I would think, however, that people, being human beings, that if they felt there was some way they were going to get a program that was going to provide them with something without costing them too much, they would want it.

COMMISSIONER FLEISCHER: And particularly if the principle you have outlined, sir, is implemented and that principle is that those who cannot afford to pay the full share of the cost or not at all, and in any not be covered by different programs in existence at the moment, they would stand to benefit?

HON. DR. ROSEN: They would stand to benefit.

COMMISSIONER FLEISCHER: And, as you know there are many classes not eligible for insurance coverage either by age or pre-existing conditions. And, still, there are people who may have an adequate income to pay a fee to a doctor but might find it very difficult if they are hit by emergencies or by protracted illness to pay these bills. So there are areas where this would

meet a definite need. Will you agree with that?

HON. DR. ROSEN: I would agree there are certain types of programs that could be developed by the general agencies that would take care of financial catastrophe for medical health care that would be appreciated by the people generally. And they would no doubt be very



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3 happy to see them put forward and subsidized by government.

4 COMMISSIONER FIRESTONE: Could you
5 visualize the special cases to be fitted into a comprehen-
6 sive medical care program for the province as a whole on a
7 voluntary basis?

8 HON. DR. ROSS: Yes, I think it could be
9 done.

10 COMMISSIONER FIRESTONE: Would you feel
11 that this would be a desirable situation for the province
12 or a desirable program for the Province of Alberta?

13 HON. DR. ROSS: I think that if you are
14 suggesting that we go along with a voluntary catastrophic
15 type of a program for everybody that is subsidized by
16 governments, and then for some of the others even in some
17 of the other catastrophic areas, they might also be helped
18 some of these other groups.

19 I think that that might be considered,
20 although I do not think it is necessary. I think that in
21 view of the fact so many people cover their total costs
22 themselves today that it does not indicate the necessity
23 for it as much. Whether this is because of the economic
24 circumstances here or difference in the attitude -- I do
25 not think it is as necessary as it might be made out to be
26 to cover everybody under this type of program.

27 COMMISSIONER FIRESTONE: As you recall,
28 we were discussing the comprehensive program on a voluntary
29 basis. This would leave it to the individual to decide
30 whether he wants to be in the program or not and such a
31 program may only come into force when a large enough
32 number of persons would indicate their willingness and



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3 interest and want to be covered in whatever formula one
4 may use. We are, therefore, talking really in terms of
5 a comprehensive program that has the support of the
6 majority of the population of the Province of Alberta.

7 COMMISSIONER FIRESTONE: The Federal
8 Government could not be expected to contribute to a program
9 that would only serve the needs of a minority. As a
10 rule, as we have seen in the hospital program, one of the
11 conditions were made of a very large proportion of the
12 people being covered.

13 HON. DR. ROSS: It is open to all people.

14 COMMISSIONER FIRESTONE: May I perhaps,
15 in conclusion, put the question in a little different way
16 to see whether a certain approach the Federal Government
17 may follow might be acceptable to the Government of
18 Alberta. I am going to stipulate these points slowly, sir,
19 to give you an opportunity to consider each point.

20 Let us assume that the Federal Government
21 came forward with a program of offering 50% of the cost of
22 a medical care insurance program on the basis of the
23 following conditions:

24 1. That the program be administered by
25 the province in co-operation with the
26 medical profession;

27 2. That minimum standards of medical
28 care services be provided on a comprehen-
29 sive basis available to everybody in the
30 province, irrespective of age, pre-
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4 HON. DR. ROSS: You put finance in there,
too, I imagine?

5 COMMISSIONER FIRESTONE: Yes, sir.

6 3. Leaving it to each province to
7 decide how to finance its share of the
8 cost, including the type of contribution
9 by those covered;

10 4. Leaving it up to each province to
11 decide whether the program should be
voluntary or compulsory in the province;

12 5. Requiring that the majority of the
13 population in the province be covered,
14 say, 75%, 85%; some such proportion;

15 6. That the majority of provinces
16 representing the majority of Canada's
17 population be covered by such a program.

18 Now, sir, if the Federal Government were
19 to come up with such a program, would this in principle
20 have the support of the Province of Alberta and I am empha-
21 sizing the words "in principle", as I realize, as you said
22 earlier, the many details to be negotiated. Perhaps you
23 can apply some of the experience you have gained under the
24 hospital program in negotiating those, but we are really
25 concerned with the basic principles and it will help us,
26 sir, if you would express your views to us.

27 If you want to consider the matter and
28 let us know on a subsequent occasion, we would be happy
29 for you to do that. But, if you have any views now we
30 would be happy to hear you.

HON. DR. ROSS: As far as point one is



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5. Requiring that the majority of the population in the province be covered, say, 75%, 80%, some such proportion;

6. That the majority of provinces representing the majority of Canada's population be covered by such a program, now, sir, if the Federal Government were

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3 concerned, the Federal Government offering 50% of the
4 cost, I think that with the present sort of financial
5 arrangement between the provinces from the point of view
6 of taxation purposes, I would feel that it should be that
7 at least. The 50% would be a reasonable contribution
8 that does not then put the Federal Government in a position
9 of being the bigger payer, and therefore the bigger voice.

10 That the program be administered by the
11 province in co-operation with the medical profession, we
12 are only talking of the medical profession here. I would
13 say in co-operation with the professions involved, yes.

14 Minimum standards of medical care of
15 services by the province on a comprehensive basis to
16 everybody, irrespective of age, previous existing condi-
17 tions, occupational groups. I think at the present time
18 the M.S.I. in Alberta -- I believe there are no restric-
19 tions, to my knowledge, at the present time, by M.S.I.
20 So that there would be no problem there.

21 COMMISSIONER FIRESTONE: I see. Fine,
22 sir.

23 HON. DR. ROSS: The question of having
24 some minimum standards of medical care services. Now,
25 this relates to -- I would take it you mean there this
26 idea of my basic type of a program ---

27 COMMISSIONER FIRESTONE: That is right.

28 HON. DR. ROSS: --- which is what I
29 feel we should consider.

30 COMMISSIONER FIRESTONE: Yes.

31 HON. DR. ROSS: Leaving it to the
32 province how to finance its share of cost, including types



concerned, the Federal Government offering 50% of the cost, I think that with the present sort of financial arrangement between the provinces from the point of view of taxation purposes, I would feel that it should be that at least. The 50% would be a reasonable contribution that does not then put the Federal Government in a position of being the bigger payer, and therefore the bigger voice. That the program be administered by the province in co-operation with the medical profession, we are only talking of the medical profession here, I would say in co-operation with the professions involved, yes. Minimum standards of medical care of services by the province on a comprehensive basis to everybody, irrespective of age, previous existing conditions, occupational groups. I think at the present time the N.S.I. in Alberta -- I believe there are no restrictions, to my knowledge, at the present time, by N.S.I. So that there would be no problem there.

104. Q. R. 1988: The question of having some minimum standards of medical care and fees. Now, this relates to -- I would like to know if you mean there this idea of my basic type of a program --

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3 of contribution by those covered. I think that is only
4 right, that the provinces be given the opportunity of
5 deciding themselves how they could best provide the
6 services, by municipal assessment, by premium system, by
7 taxation or co-insurance, whatever it is. This, I think,
8 is the province's responsibility.

9 No. 4: leaving it up to each province
10 to decide whether the program should be voluntary or
11 compulsory in the province. There is only one thing to
12 do and that would be voluntary. We have stood on this
13 for 25 or more years, and it would be voluntary.

14 COMMISSIONER FIRESTONE: May I pursue
15 this question so there will be no misunderstanding as to
16 the purpose of the question.

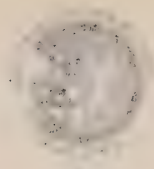
17 If the Federal Government developed a
18 plan, and we are leaving it to each province to decide
19 whether it wishes this program on a voluntary or compulsory
20 basis -- Alberta may wish to have it on a voluntary basis;
21 another province may wish it on a compulsory basis -- you
22 would have no objection to letting each province decide
23 what is proper for their people?

24 HON. DR. ROSS: That is a provincial
25 responsibility, quite right.

26 COMMISSIONER FIRESTONE: You would accept
27 leaving it up to each province, whether it should be volun-
28 tary or compulsory?

29 HON. DR. ROSS: Absolutely.

30 COMMISSIONER McCUTCHEON: Just one
question, sir. Let us suppose that the Federal Government
made an offer such as my friend described. Let us suppose



of contribution by those covered. I think that is only right, that the provinces be given the opportunity of deciding themselves how they could best provide the services, by municipal assessment, by premium system, by taxation or co-insurance, whatever it is. This, I think, is the province's responsibility.

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COMMISSIONER LESTER: You would accept

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COMMISSIONER MCGILL: Just one

question, sir. Let us suppose that the Federal Government made an offer such as my friend described. Let us suppose



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3 the figure was \$20,000,000 expenditure in the Province of
4 Alberta, and I have no idea what the figure is, but would
5 you prefer to have that offer of \$20,000,000 made in the
6 way described, or would you prefer the \$20,000,000 paid
7 to you to apply in the order of priority of what you
8 think is most important in the health field?

9 HON. DR. ROSS: Well, I would prefer to
10 have it provided so that each province could then decide
11 what it considered most necessary for itself.

12 COMMISSIONER McCUTCHEON: I take it from
13 what you said a few minutes ago that you do not regard
14 this universal comprehensive medical care coverage being
15 the first priority in Alberta?

16 HON. DR. ROSS: I do not.

17 COMMISSIONER FIRESTONE: I take it, Mr.
18 Minister, that if a program were to be evolved -- because,
19 in the opinion of a number of governments in Canada and
20 in the opinion of a lot of people in Canada, there is a
21 desire to develop such a program -- you would be willing
22 to consider participating in such a program along certain
23 terms, and what really we are doing at the moment is
24 discussing the possibility of such a program. I under-
25 stand you are willing to consider such terms?

26 HON. DR. ROSS: I would say -- and I do
27 not say it unfairly -- we would have no other choice.
28 And this is what has happened in the past. You have no
29 other choice when a Federal Government comes up with a
30 program which means a considerable amount of money to the
province, providing they come up with a plan.

COMMISSIONER McCUTCHEON: That is what you



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COMMISSIONER MACDONALD: That is what you



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4 mean by the progressive intrusion by the Federal Government
5 into areas where it has no constitutional right to involve
6 itself?

7 HON. DR. ROSS: Right.

8 However, we would be prepared to discuss
9 it, but I think this is the type of thing that certain
10 provincial governments, particularly if they are not of
11 the same political type as the one in power -- because
12 they are placed in a position politically. We have to
13 face it today. They are faced with turning down an offer
14 of our hospitalization program of some \$20,000,000 --
15 maybe \$20,000,000. We have an election probably next
16 year and you have an awful job selling yourself after
17 turning down \$20,000,000, which we recognize as our money,
18 which has been taken out as taxation, income and otherwise.

19 COMMISSIONER FIRESTONE: I take it, Mr.
20 Minister, if such a proposal were forthcoming from the
21 Federal Government for the development of such a medical
22 care plan, it would develop and be forthcoming because
23 there is an apparent overwhelming demand for such a plan
24 across Canada, and that Alberta would want to participate
25 in a plan which would be a national plan?

26 HON. DR. ROSS: I am afraid I would have
27 to disagree that there is an overwhelming demand across
28 Canada for a comprehensive medical program, and I may be
29 way off in left field, but ---

30 THE CHAIRMAN: Or right field?

MR. FRAWLEY: Touché.

HON. DR. ROSS: But I think that, as
politicians, we often -- and I am only referring to myself --



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3 that we often give the impression that many of the things
4 that we are proposing are the wish and desire of the
5 people. I think that sometimes, and many times, they
6 are. A proper government knows what its people are
7 thinking. I think there are times when programs are put
8 forward that the people have not given a great deal of
9 thought about.

10 COMMISSIONER FIRESTONE: I take it in a
11 case like that it appoints a Royal Commission?

12 HON. DR. ROSS: May I say that I think
13 that the number of people represented by the brief
14 perhaps do not quite understand what all the people think,
15 sir.

16 COMMISSIONER FIRESTONE: I think there
17 were one or two points on your list, sir.

18 HON. DR. ROSS: Yes, there were.

19 Requiring that the majority of the
20 population in the province be covered. I can quite well
21 understand that no Federal Government could properly be
22 providing sums of money without having a majority of
23 population in an area covered. Although, again, I feel
24 that if you could work out -- and I think it could be done
25 -- what are the costs for some groups that need assistance,
26 that this can be done on a per capita basis contribution
27 of a Federal Government to the province to help them in
28 that particular area that they felt needed help.

29 COMMISSIONER FIRESTONE: I take it if
30 there were a requirement for a majority of the population
of the order of 75% or 85% that you would consider this a
reasonable proportion?



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HON. DR. ROSS: Some of the people think 65% is too high a majority in this province.

COMMISSIONER FIRESTONE: I am not enquiring as to what area you refer to but in medical care services would you feel this proportion ---

HON. DR. ROSS: I think 75% might be adequate. The majority of the province - the majority of the Canadian population to be covered by such programs. We ran into this in the hospital program where the Federal Government did change its attitude. It did require this at the start and then entered into easier shares with the provinces of Saskatchewan, Alberta, that came in as of 1st July - Saskatchewan, Alberta and British Columbia. They were the three provinces which did not represent the majority but they changed their ideas there and I think you would find they would change them here too.

COMMISSIONER FIRESTONE: You have been very helpful. If I might summarize what you have been telling me to see if I have a proper appreciation of what you have put before the Commission. If I understand you correctly you would be in favour of a comprehensive medical care program to which those that can afford to contribute would contribute and those that cannot afford to pay either in full or in part, have their payments made by the State with the provincial government and the Federal Government contributing on the basis of a formula to be agreed upon by the two levels of government?

HON. DR. ROSS: I think that is correct.

COMMISSIONER FIRESTONE: Thank you very much.



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you have put before the Commission. If I understand you

correctly, you are suggesting that the Government should

contribute to the cost of the program and to share the cost

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COMMISSIONER FIRESTONE: Thank you very



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COMMISSIONER BALTZAN: I have not any set number of questions for you but a number of things that have arisen out of the discussions before. In reading through the brief I got the impression that you advocate and endorse the principle of co-insurance chiefly on the basis of people's desire to participate in sharing the cost. Is that your idea?

HON. DR. ROSS: It is basically to have them recognize their responsibilities in being a partner in the cost of a program.

COMMISSIONER BALTZAN: That is the impression I got and I just wanted that for the public record. It was not used, it has been raised to be used as a deterrent factor although it was maximum and I have cognizance of three places in your brief where you skated around the thing a little bit. The main principle is as you originally advocate it? Now the point

HON. DR. ROSS: It makes them recognize they are sharing in a program. As I mentioned before I think there may be some slight deterrent at times but not a great deal.

COMMISSIONER BALTZAN: Not used necessarily as a penalty?

HON. DR. ROSS: No.

COMMISSIONER BALTZAN: Now, just this; is there not an increasing public demand for diagnostic services? We have been talking about management of hospitals and we have been talking about medical staffs having certain responsibilities and we sort of left Mr. Public out in centre field, not right or left field. Generally



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4 an increasing demand, from your experience?

5 HON. DR. ROSS: I would say there is an
6 increasing need for diagnostic procedures in the involved
7 areas of medical diagnosis today. I still maintain that
8 if the doctor depends upon his diagnostic machinery rather
9 than his brain to take a good history and do a full
10 physical examination then he might as well leave his
11 diagnostic machine at home. The important thing in medi-
12 cine is the history and examination to determine to what
13 areas he should use his diagnostic facilities. It is
14 important in the advancing field of medicine.

15 COMMISSIONER BALTZAN: You are against
16 this current affair of the artificial type of examination
17 by machinery and so on?

18 HON. DR. ROSS: I am.

19 COMMISSIONER BALTZAN: From the point
20 of view of the public would you say that there is a demand
21 on the part of the public for these things, an increasing
22 demand?

23 HON. DR. ROSS: I think the doctor is
24 being perhaps besieged more today than he was five or ten
25 years ago to be clinicked and he has difficulty in under-
26 standing the pressures of his patients to do many tests
27 upon them that his proper examination and history will
28 perhaps indicate is not required. He has a pressure on
29 him that he feels he has to satisfy and then he uses or
30 misuses.

31 COMMISSIONER BALTZAN: I can quite under-
32 stand that. I am not putting my question in any sense to



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4 criticize the public for their demand, I even go so far as
5 to sympathize with them in their demand. Now, it is true
6 that people want more medical examinations, periodic
7 examinations?

8 HON. DR. ROSS: Yes, I think that is the
9 experience of most doctors in practice.

10 THE CHAIRMAN: Is this invoked at all
11 by the advertising we hear on the radio to see your
12 doctor every so often?

13 HON. DR. ROSS: I think so, and all the
14 articles that appear in the scientific journals like
15 Reader's Digest.

16 THE CHAIRMAN: I am glad to hear you
17 call it scientific.

18 COMMISSIONER BALTZAN: But there are
19 health agencies?

20 HON. DR. ROSS: Yes.

21 COMMISSIONER BALTZAN: People with great
22 interest who will tell the people "Observe your symptoms,
23 come and see us early" and they obey and see them. The
24 public is alerted by legitimate warnings given from autho-
25 ritative sources?

26 HON. DR. ROSS: Yes.

27 COMMISSIONER BALTZAN: So we can assume
28 that some recognition must be given to the fact that,
29 whatever the prompting cause is, there is an increasing
30 demand. Now, that is apart from where there is an increa-
sing need but there is an increasing demand.

31 Lastly, Dr. Ross, something arose out of
32 discussions this morning in relation to this element of



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8 that is the administrative services as well as medical
9 services. That is not always possible and you have
10 certain provisions I am cognizant of if that was carried
11 a little too far and it could be those two agencies in
12 rendering that service, hospitalization and the treatment
13 and avoiding utilization, etc., if this was carried a
14 little too far to meet the ceiling that is projected
15 there is a danger and maybe a poor quality of service.

16 Let us put it this way: that there might
17 be just not enough oxygen used if oxygen is required.
18 Carrying it a little too far, that is, but I have known
19 that or heard it from other sources. There is that
20 danger.

21 HON. DR. ROSS: I would say that it is
22 the responsibility of the people involved in controlling
23 to make sure that the first thing that you take cognizance
24 of is the patient who requires the care, to see that he
25 gets an adequate, good quality type of care. I have used
26 the terms Cadillac service or Dodge service. I think
27 some hospitals might like to give a Cadillac service but
28 the people of Canada, I think, probably can afford a
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6 quality of care, always keeping in mind that it is the
7 patient they are responsible for.

8 COMMISSIONER BALTZAN: And we in Canada,
9 as you have said, have been producing perhaps the best
10 kind of medical care anywhere.

11 HON. DR. ROSS: I think we have, yes.

12 COMMISSIONER BALTZAN: I would like you
13 to repeat that.

14 HON. DR. ROSS: I personally feel that
15 we have. Again I say perhaps I am biased because I am a
16 Canadian but I have had occasion to see people from other
17 countries and talk to them about medical care and I do not
18 think there is any question that the quality of the doctors
19 turned out from our medical schools and the quality of the
20 facilities they have available, the nurses and all the
21 personnel involved in medical and hospital care are top
22 quality people.

23 COMMISSIONER BALTZAN: These same people
24 you are talking about frequently find themselves, I
25 assume, under the hammer, under certain pressures to
26 produce this high quality of service and then a demand on
27 the part of the individual. Finally, I was pleased with
28 your reference so many times that you have known this
29 sort of situation in your own practice, administration
30 wants to shorten the stay, medical staff wants to shorten
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3 factor of the public, the family, the patient's desire
4 and the rules are broken, are they not?

5 HON. DR. ROSS: They sometimes are but
6 I think in the minority of the cases. I think it is a
7 small percentage of cases that that occurs and I think
8 we probably will always have that with us.

9 COMMISSIONER BALTZAN: I think so.

10 Mr. Frawley, may I ask this question of
11 you? Under the British North America Act responsibility
12 for the health of the people of Canada was assigned to
13 the jurisdiction of the provinces. I am so very ill-
14 informed about the law, could you tell me perhaps within
15 that context what was the extent of the responsibility,
16 was it defined?

17 THE CHAIRMAN: Books have been written
18 on it, I do not think we can expect Mr. Frawley to cover
19 it this afternoon.

20 MR. FRAWLEY: I was going to say I
21 would not know where in Section 91 or 92 to put my finger
22 on the sub-section or the head that would justify that
23 statement, but I think it is there.

24 THE CHAIRMAN: The original basis of a
25 complete assignment to one or the other is not factual,
26 there is the basic responsibility with the province, some
27 residual responsibility left with the Dominion in connec-
28 tion with Indians, seafarers, etc. Your premise is not
29 right legally. A lawyer can make a wrong answer even if
30 he starts with a correct premise.

31 COMMISSIONER BALTZAN: And it is a wrong
32 thing for a doctor to ask a question like that. Thank



factor of the public, the family, the patient's desire
and the rules are broken, are they not?
HON. DR. ROSS: They sometimes are but
COMMISSIONER BALDWIN: I think so.
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you? Under the British North America Act responsibility
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3 you very much.

4 COMMISSIONER GIRARD: On page 47 in the
5 last paragraph you say:

6 "Currently, a nursing education survey
7 committee of five is studying all
8 aspects of nursing education and the
9 associated problems of recruitment of
10 the different types of nursing personnel
11 required in satisfactory operation of
12 the Alberta Hospitalization Benefits
13 Plan".

14 I understand that this survey committee,
15 the nursing education survey committee, is done by the
16 Government under the auspices of the Department of Health,
17 not by the Nursing Association?

18 HON. DR. ROSS: No, that is right.

19 COMMISSIONER GIRARD: May I ask you
20 what prompted this survey or what are the underlying
21 reasons for this type of survey in nursing education?
22 Also I would like to know what application do you foresee
23 of the outcome of this?

24 HON. DR. ROSS: Well, what prompted
25 this was that last year I had a two-day bull session
26 with a lot of people in the health field of Alberta to
27 discuss, mutually discuss, some of the problems that we
28 felt were present and that we thought we could get
29 together and chew it out and see what might come out of it.
30 This is, as I say, one of these - I suppose it is not an
appropriate term to call it a bull session - that is what
it amounted to, anyway, and we sat around the table in the



you very much.

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last paragraph you say:

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3 conference room for a couple of days. We had an agenda
4 of various things we wanted to discuss. This was a
5 conference I called myself and we had the Nurses'
6 Association, the Hospital Association, the Medical Associa-
7 tion; we had a varied group of people involved from the
8 University and any other groups. Out of this there were
9 some recommendations which came to the Minister and one
10 was that a committee be set up. I discussed this and
11 after discussing with a number of people about it I
12 chose Dr. Earle Scarlette who is a well-known medical
13 figure in this province and former Chancellor of our
14 University and a representative from the Hospital Associa-
15 tion although not chosen as such, Mr. Adshead. He was
16 with the University Hospital as an administrator and is
17 now with Foothills. Miss Johnson, who serves as superin-
18 tendent at the Royal Alex Hospital for a few years, and
19 who has graduated there. Then Miss Campbell from the
20 University Faculty of Nursing and Mr. Maday from our
21 Department of Hospitals Division. Although there were
22 certain things that we did discuss, certainly they were
23 not limited. We discussed what we felt was needed to
24 study so we could meet the future health needs of our
25 province from the point of view of the expanded hospitaliza-
26 tion service, nursing services, that are required in
27 public health and possibly home nursing and the V.O.N.
28 and all those areas. We spoke too not merely of the
29 graduate nurse but the nurses' aids, the orderlies, those
30 various members of the nursing team, to determine what
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3 areas or different types of programs of training that
4 might make this type of personnel available when they
5 were needed. These people presently are at work making
6 this study and I understand will be making some preliminary
7 report in the not too distant future although I would
8 question whether there will be any complete program or
9 recommendations to bring before us until this Fall.

10 COMMISSIONER GIRARD: Were any of these
11 various groups of people that you mentioned dissatisfied
12 with nursing education as it is today? Is that what
13 prompted this full investigation into nursing education
14 or is it rather that you are looking into the nursing
15 education as a first step of solving the nursing service
16 problems?

B/dw 17 HON. DR. ROSS: I think that you have to
18 look into the nursing education to see. You have to
19 project your needs and through the projections you
20 can foresee in the future, and then you have to look at
21 your present situation and see whether this might be
22 extended and what ways it can be extended or whether the
23 program might be modified to turn out more adequately
24 trained personnel. Whether they are dissatisfied with
25 the nurses of today I wouldn't dare to make a statement
26 on that.

27 COMMISSIONER GIRARD: You can very well
28 because I think the nurses themselves are in an introspec-
29 tive mood just now. The Canadian Nurses' Association
30 itself is looking very deeply into the nursing education
policy. The only difference is that the Canadian Nursing
Association, when it had the survey on nursing education,

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3 decided to have a person that was entirely outside of
4 nursing or of the medical field or para-medical field
5 in order to, from that study, get a very objective look
6 at nursing. Whatever you say about nursing we also say.
7 I wondered if this survey came out of some group being
8 dissatisfied with the methods of nursing education and
9 saying "Well now, let's study and see if we can find
10 better methods". It is said and done.

11 THE CHAIRMAN: It is being said.

12 COMMISSIONER GIRARD: It is being done.

13 I think there have been attempts to find different ways
14 of nursing education, different programs.

15 HON. DR. ROSS: I would think myself,
16 Miss Girard, if you have somebody who is entirely separate
17 from the medical or para-medical field that they may be
18 influenced too much by emotional impact to look realisti-
19 cally at it. I think that people who have lived with it
20 all their working lives will look at it more realistically
21 and perhaps with not quite as friendly a view to their own
22 kind as would somebody outside.

23 COMMISSIONER GIRARD: I think you can
24 think of some person outside the medical or para-medical
25 field as being a consumer of nursing services and they
26 consider what they like in nursing services. Mr. Minister,
27 when do you think this survey will be finished and will it
28 be possible for us to have your report of this?

29 HON. DR. ROSS: We would be happy to give
30 you a report of it. Dr. Scarlett indicated there would be
some preliminary report coming in. I had hoped to have
an opportunity, as I say, of reconvening this group that



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3 initiated this in the first place some time this summer
4 or early Fall. I hope they will have enough material
5 then for an interim report to go out. We would be quite
6 happy to send you the report.

7 COMMISSIONER GIRARD: We would be happy
8 to have the report. Thank you, Mr. Minister.

9 THE CHAIRMAN: Dr. Van Wart?

10 COMMISSIONER VAN WART: One question:
11 it is on the question of tuberculosis hospitals; do any
12 of your tuberculosis hospitals employ pharmacists?

13 HON. DR. ROSS: We employ pharmacists
14 in both of them.

15 COMMISSIONER VAN WART: In your mental
16 hospitals?

17 HON. DR. ROSS: Yes.

18 COMMISSIONER VAN WART: That is all, sir.

19 THE CHAIRMAN: Dr. Strachan?

20 COMMISSIONER STRACHAN: Mr. Chairman,
21 Mr. Minister, page 15, paragraph 53:

22 "The Department of Public Health makes
23 available federal professional training
24 grants on the recommendation of the
25 Deputy Minister of Health".
26 Is that the Federal Department of Public
27 Health?

28 HON. DR. ROSS: No, no.

29 COMMISSIONER STRACHAN: Provincial
30 Department?

31 HON. DR. ROSS: The Provincial Department.
32 There are Federal, Provincial, Federal health grants and



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Is that the Federal Department of Public
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HON. DR. ROSS: No, no.

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3 included in that are federal professional training grants
4 that come in under our Department for allocation.

5 COMMISSIONER STRACHAN: What are the
6 amounts and the application of them?

7 HON. DR. ROSS: Mr. Homan, what is the
8 amount of the professional training grants?

9 MR. HOMAN: National training grants
10 for all of Canada are allocated to the provinces on their
11 population basis. I could give you the figures in
12 dollars over the years for Alberta if you wish to have
13 them, Mr. Chairman.

14 HON. DR. ROSS: Have you got the approxi-
15 mate amounts? Here are professional training grants,
16 \$126,936 for the years 1960 to 1961 and the amount
17 expended \$106,507.26, 83%.

18 THE CHAIRMAN: What page are you reading
19 from?

20 HON. DR. ROSS: Page 29, Chief Justice
21 Hall, I am sorry. Page 29 is also the grants that were
22 available.

23 COMMISSIONER STRACHAN: These are
24 rather large figures. How does it work out individually?

25 HON. DR. ROSS: This would depend on the
26 type of training program that is undertaken. There is
27 professional training for nurses going on, post-graduate
28 courses in public health. We use it for instructors,
29 training instructors, sanitary inspectors. There are
30 many areas open. It is for people in our province who
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4 MR. HOMAN: Training in medical and
5 nursing, medical nursing, both within the Department
6 and within the hospitals.

7 COMMISSIONER STRACHAN: Let us be more
8 specific and stay with this paragraph. You refer to
9 these grants being available to dentists in public health
10 services. Is that for a dentist, graduate dentists, who
11 are taking post-graduate work in public health work?

12 MR. HOMAN: It could be, yes sir.

13 COMMISSIONER STRACHAN: What would be
14 the amount granted?

15 MR. HOMAN: Depending on the social
16 status of the individual as to being married or single
17 there would be available a bursary to the individual plus
18 the payment of his tuition and transportation and book
19 allowance. Where there is need for a training, post-
20 graduate training of dentists or a doctor, no matter what
21 it is, pathologists and so on and so forth.

22 COMMISSIONER STRACHAN: What might that
23 amount be per year for the dentist taking post-graduate
24 work, approximately?

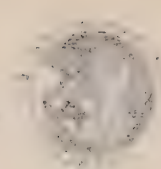
25 MR. HOMAN: The federal level stipend
26 on that is \$250 per month on stipend.

27 COMMISSIONER STRACHAN: Over a period
28 of what?

29 MR. HOMAN: His University program which
30 is approximately eight months.

COMMISSIONER STRACHAN: If it is two,
three years?

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1 go on over two years. For example, in psychiatry, it is
2 a four-year program. Now, that whole four-year program
3 may or may not entirely be a period of bursary, but it
4 would be a four-year training program. We have some that
5 are the entire four-year program on bursaries, the individual requires the bursary over that period of time.

6 COMMISSIONER STRACHAN: Are they obliged
7 to return?

8 MR. HOMAN: There is a return service
9 requirement.

10 COMMISSIONER STRACHAN: Year for year?

11 MR. HOMAN: Year for year.

12 COMMISSIONER STRACHAN: How does this
13 apply to dental auxiliaries?

14 MR. HOMAN: There is a return of two
15 years because it is a two-year training program. This is
16 new legislation introduced in Alberta last year.

17 COMMISSIONER STRACHAN: These girls now
18 in training at ---?

19 MR. HOMAN: The University of Alberta.

20 COMMISSIONER STRACHAN: The University --
21 are all obliged to come back to the Department of Public
22 Health?

23 MR. HOMAN: They can elect not to, and
24 repay in cash.

25 HON. DR. ROSS: The thing is there, Dr.
26 Strachan, in this dental auxiliary program, this was a new
27 pair of hands. Perhaps Dr. McPhail, if he is present,
28 would like to answer you. He is Director of Dental Public
29 Health. This was to get an extra pair of hands for the
30 dentists out in the preventive dental fields on our health
units in the rural areas. We will be requiring these
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5 rather than in the city for a start. We are attempting
6 to meet dental prevention out in the outlying areas of
7 the province by giving the dentists an extra pair of hands.

8 COMMISSIONER STRACHAN: Auxiliary educa-
9 tion effort.

10 HON. DR. ROSS: It is both. Is Dr.
11 McPhail here?

12 DR. McPHAIL: Yes.

13 HON. DR. ROSS: Dr. McPhail may answer
14 that.

15 DR. McPHAIL: The program includes health
16 education and preventive measures which include prolalix
17 and use of topical fluorides.

18 COMMISSIONER STRACHAN: Will these auxi-
19 liaries be working under the supervision or direction of
20 a dental officer?

21 DR. McPHAIL: Supervision of a dental
22 officer.

23 COMMISSIONER STRACHAN: Will he be with
24 him personally?

25 DR. McPHAIL: There will be a dental
26 officer in charge.

27 COMMISSIONER STRACHAN: They will be
28 working in the presence of each other?

29 DR. McPHAIL: Not necessarily, no. She
30 will be working under his direction or supervision.

31 COMMISSIONER STRACHAN: Thank you, Dr.
32 McPhail.



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3 Mr. Minister, referring to your Nursing
4 Aids' Act of 1947, are male applicants considered in this?

5 HON. DR. ROSS: I don't believe we have
6 ever had a male apply for this. Dr. McCallum?

7 DR. MCCALLUM: This problem has been
8 discussed a number of times, but partially due to the
9 fact there weren't many wanted it and the fact our facili-
10 ties don't adapt themselves to male, female education at
11 the same time, it has never been picked up although we
12 still think of it in the future as far as that is
13 concerned.

14 HON. DR. ROSS: The answer I have always
15 got, would you like a man to be giving you your nursing
16 care when you were in the hospital? I am afraid the
17 male nurse will never be a popular addition to the nursing
18 staff of a hospital.

19 COMMISSIONER STRACHAN: They do it as
20 well.

21 HON. DR. ROSS: They may do as well, but
22 only in some areas.

23 THE CHAIRMAN: Psychiatric.

24 HON. DR. ROSS: Tender loving care.

25 COMMISSIONER STRACHAN: That wasn't where
26 I received mine, I would like you to understand.

27 THE CHAIRMAN: Perhaps that's where I
28 got my information.

29 COMMISSIONER STRACHAN: Referring to
30 page 32, paragraph 100, where you have an agreement with
the Alberta Dental Association on the basis of 40% per
capita per month for social dental services. If my



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30 capita per month for social dental services. If my



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3 mathematics are correct, last year the total services
4 were \$20,000, almost \$21,000, less than agreed to.

5 HON. DR. ROSS: I am sorry, this 40¢
6 per capita per month amounts to \$480 per year, and we have
7 35,000 or close to 50,000.

8 COMMISSIONER STRACHAN: 51.

9 HON. DR. ROSS: 50,000 now covered by
10 this program. The agreement is for the provision of
11 dental services to the patients with the understanding
12 that for dentures and relinings the patient pays half
13 the cost of that himself. There is a limitation on the
14 orthodontic work that is given under this. The amount
15 that the dentist gets, the percentage he gets, I really
16 don't know. There was a special schedule of fees they
17 had in dealing with the Government for this type of
18 patient that is agreed on. I understand they were paying
19 close to 100% of that schedule, but again I understand
20 it wasn't their regular schedule of fees for your ordinary
21 public. There was a special schedule for this. Perhaps
22 the Dental Association may have some comment on that in
23 their brief.

24 COMMISSIONER STRACHAN: Do you pay this
25 40¢ per capita per month?

26 HON. DR. ROSS: To the Dental Association.

27 COMMISSIONER STRACHAN: Yes. If they
28 have any surplus for one year may that use that next year?

29 HON. DR. ROSS: That is their money.

30 COMMISSIONER STRACHAN: That is their
money. They might possibly render that much more service
the next year.



mathematics are correct, last year the total services

were \$20,000, almost \$21,000, less than expected to

HON. DR. ROSS: I am sorry, this was

per capita per month amounts to \$480 per year, and we have

\$5,000 or close to \$5,000.

COMMISSIONER STRACHAN: Sir,

HON. DR. ROSS: \$5,000 now covered by

this program. The agreement is for the provision of

dental services to the patients with the understanding

that for dentures and relinings the patient pays half

the cost of that himself. There is a limitation on the

orthodontic work that is given under this. The amount

that the dentist gets, the percentage he gets, I really

don't know. There was a special schedule of fees they

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COMMISSIONER STRACHAN: That is their

money. They might possibly render that much more service

the next year.



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3 HON. DR. ROSS: We hope they might. I
4 think, again, our relations with the Dental Association
5 have been very cordial and excellent relations.

6 COMMISSIONER STRACHAN: Now, Mr. Minister,
7 referring to another subject, on several occasions today
8 you have expressed a personal opinion. I am going to
9 ask you a straightforward question which will be answered
10 very readily by yes or no. Are you personally in favour
11 of fluoridation?

12 HON. DR. ROSS: Yes, personally, I said.

13 COMMISSIONER STRACHAN: Personally,
14 that is the question I asked. Is your Department in
15 favour of fluoridation?

16 HON. DR. ROSS: My Department is a
17 Department of government, and the Department - the
18 policy of the Department is determined by the policy of
19 government, not by myself personally.

20 THE CHAIRMAN: You have legislation on
21 the books of Alberta dealing with fluoridation?

22 HON. DR. ROSS: We have legislation in
23 the statutes that permits the people of an area to choose
24 fluoridation or to reject it.

25 THE CHAIRMAN: On a 66 and two-thirds
26 majority.

27 HON. DR. ROSS: On a 66 and two-thirds
28 majority.

29 COMMISSIONER STRACHAN: It must be by
30 plebiscite?

HON. DR. ROSS: Yes, they must have a
plebiscite before they can get it.



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COMMISSIONER STRACHAN: Now, Mr. Minister

referring to another subject, on several occasions today

you have expressed a personal opinion. I am going to

ask you a straightforward question which will be answered

very readily by yes or no. Are you personally in favour

of federation?

HON. DR. ROSS: Yes, personally, I said.

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policy of the Department is determined by the policy of

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THE CHAIRMAN: You have legislation on

the books of Alberta dealing with federation?

HON. DR. ROSS: We have legislation in

the statutes that permit the people of an area to propose

federation or to reject it.

THE CHAIRMAN: In a 50 and two-thirds

HON. DR. ROSS: On a 50 and two-thirds

majority.

COMMISSIONER STRACHAN: It must be by

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HON. DR. ROSS: Yes, they must have a

majority before they can get it.



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4 COMMISSIONER STRACHAN: We have been
5 speaking of deterrents, and it is a fact that recognized
6 health authorities of the world have repeatedly endorsed
7 fluoridation. It is a fact that fluoridation reduces
8 decay by 60%. It is also a fact for years to come we
9 face a shortage of dental personnel. May I ask what
10 the reasoning of your Department or your Government is
11 that they place a deterrent to fluoridation by requiring
12 a 66 and two-thirds majority?

13 HON. DR. ROSS: This is a question that
14 has been decided by the Legislative Assembly of the
15 province, not by me personally.

16 COMMISSIONER STRACHAN: Don't they take
17 the advice of your Department?

18 THE CHAIRMAN: It would be a wonderful
19 idea, wouldn't it?

20 HON. DR. ROSS: I may bring legislature,
21 recommend legislature and they may throw it back in my
22 face, and sometimes do. This is a democracy.

23 THE CHAIRMAN: I say this very seriously,
24 I don't think it is in the province of this Commission
25 to question governments on governments' policy.

26 HON. DR. ROSS: Thank you.

27 THE CHAIRMAN: Otherwise no Minister
28 would appear before us.

29 We will take a few minutes recess, and
30 then proceed, Mr. Frawley, with your drug submission.

--- A Short Recess



COMMISSIONER STRACHAN: We have been speaking of corporations, and it is a fact that recognized health authorities of the world have repeatedly endorsed fluoridation. It is a fact that fluoridation reduces decay by 80%. It is also a fact for years to come we face a shortage of dental personnel. May I ask what the reasoning of your department or your government is that they place a deterrent to fluoridation by requiring a 66 and two-thirds majority?

MR. ROSS: This is a question that has been decided by the Legislative Assembly of the province, not by me personally.

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THE CHAIRMAN: I say this very seriously. I don't think it is in the province of this Commission to question governments on government's policy.

THE CHAIRMAN: Otherwise no Minister would appear before us.

We will take a few minutes recess, and then proceed, Mr. Hawley, with your third submission.



JO/dpw

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3 THE CHAIRMAN: Yes, Dr. Ross.

4 HON. DR. ROSS: Mr. Chairman, I noticed
5 in No. 3, the Department of Public Welfare mentioned
6 here, and I understand a letter was sent to our Minister
7 Mr. Rogers, the Deputy Minister, is here. This relates
8 to medical costs and services for indigents, and most
9 of this is covered through the medical services of the
10 Department of Health, and for some of the indigents and
11 the drugs, they are carried out through normal channels
12 and paid for. They rely to an extent on the Department
13 of Health to carry on and look after their program in
14 this area, so that unless there were some questions you
15 would like Mr. Rogers to answer, I think most of it is
16 covered by our submission.

17 THE CHAIRMAN: I think there was one
18 question which Mr. McCutcheon put in essence which we
19 were concerned about, and that is whether in the
20 Province of Alberta, from the case histories in the
21 Department of Social Welfare, you could say whether
22 there were any, and if so, the number of those who had
23 done without medical attention for want of the ability
24 to pay?

25 HON. DR. ROSS: Well, I would think
26 that it would be improper for me to answer that on
27 behalf of Mr. Rogers, because if there had been any
28 complaints on this they would have come to his attention,
29 or to his Ministers. But I am sure that had they come
30 to them I would have been made aware of them. I believe
they would be few, if any, and if Mr. Rogers is still
here --- yes, I see he is.

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in No. 3, the Department of Public Welfare mentioned here, and I understand a letter was sent to our Minister Mr. Rogers, the Deputy Minister, is here. This relates to medical costs and services for indigents, and most of this is covered through the medical services of the Department of Health, and for some of the indigents and the drugs, they are carried out through normal channels and paid for. They rely to an extent on the Department of Health to carry on and look after their program in this area, so that unless there were some questions you would like Mr. Rogers to answer, I think most of it is covered by our legislation.

THE CHAIRMAN: I think there was one question which Mr. Hutchinson put in essence which we were concerned about, and that is whether in the Province of Alberta, from the case histories in the Department of Social Welfare, you could say whether there were any, and if so, the number of those who had gone without medical attention for want of the ability to pay?

HON. DR. ROSS: Well, I would think

that it would be improper for me to answer that on behalf of Mr. Rogers, because if there had been any complaints on this they would have come to his attention, or to his Ministers. But I am sure that had they come to them I would have been made aware of them. I believe they would be few, if any, and if Mr. Rogers is still here --- yes, I see he is.



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4 Mr. Rogers, have you had any complaints
5 of any people, indigents, not being able to receive
6 medical services because they could not pay?

7 MR. ROGERS: Well, I think it is a
8 fair statement, sir, that any person in Alberta who is
9 in need of medical attention is able to receive that
10 attention.

11 THE CHAIRMAN: It is a matter of proce-
12 dure. We heard in one province or another that they got
13 the run-around before being able to get it. What is the
14 procedure?

15 MR. ROGERS: Like some other provinces,
16 Alberta has various welfare authorities divided between
17 the province and the municipalities. Each has its own
18 jurisdiction. But there are provisions under both autho-
19 rities to pay medical attention as it is needed.

20 THE CHAIRMAN: For those who are unable
21 to pay?

22 MR. ROGERS: Yes, yes.

23 THE CHAIRMAN: Yes. Thank you very
24 much.

25 There was another phase of it that Dr.
26 Firestone will inquire about.

27 COMMISSIONER FIRESTONE: The question
28 is either addressed to you or to Mr. Rogers, or any
29 other person you designate. Some hospitals face a
30 problem, particularly with patients that are not in an
acute stage of ill health, and that could be returned
to their homes, if they have homes, or to homes for the
aged, the infirm, or to homes, say, for senior citizens.

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4 What is the practice in the Province of
5 Alberta in this field?

6 HON. DR. ROSS: Well, perhaps if I lead
7 off, and then if Mr. Rogers wishes to add anything, he
8 may answer.

9 In the hospital programming for Alberta,
10 as I mentioned earlier, we have recognized the need for
11 the care of the long-term illness, and we have embarked
12 upon a program known as our Auxiliary Hospital Program
13 decentralized throughout the total area of our province --
14 that represents a 50-bed size in the rural areas, and
15 100-bed size in the cities -- situated close to and
16 joined with an active hospital in order to reduce the
17 cases of duplicate service, and to see that the doctors
18 were easily available to the patients there for long-
19 term care. These are being built up around our province
20 now, and we feel that we will eventually take care of
21 the problem of the long-term patient.

22 Unfortunately, there are people, however,
23 who are considered domiciliary or custodial care. This,
24 we believe, is a welfare responsibility and at present
25 some of the nursing homes we had under contract in
26 Calgary for hospitalization of long-term patients have
27 been de-contracted, and because many of them were caring
28 for custodial care after our assessment and their level
29 of accommodation was such that we felt they could not
30 meet hospital care standards and welfare are now looking
after those patients who qualify under the means test
and are being looked after in these homes.

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3 that is going to give us problems in the future. The
4 people who can care for themselves and need some care
5 are being looked after in our homes for the aged, which
6 is a program of the Department of Welfare and it has
7 homes situated throughout the province to care for the
8 people who no longer wish to live alone, out on the farm,
9 or the bachelor, or aged, who feel themselves it is the
10 accommodation they are after, it is in general the answer.

11 THE CHAIRMAN: Mr. Rogers was going to
12 add something.

13 COMMISSIONER FIRESTONE: Could you
14 perhaps elaborate a little on how this home care or
15 these homes for the aged work? How does this program
16 work out in practice?

17 MR. ROGERS: You are referring to homes
18 for senior citizens?

19 COMMISSIONER FIRESTONE: Yes, sir.

20 MR. ROGERS: This is a program for those
21 people who are quite capable of managing for themselves.
22 The province undertook a program of providing the accommo-
23 dation for a number of people. They built homes and
24 Boards of Foundation were established and made up of
25 representatives of participating municipalities. When
26 the home was completed, it was turned over to the
27 Foundation and the Foundation operates the home.

28 THE CHAIRMAN: Are national housing
29 funds available to you for that?

30 MR. ROGERS: No, sir.

HON. DR. ROSS: This was the first year
of our five-year program, Mr. Chairman, and these funds



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HON. DR. ROSS: This was the first year

of our five-year program, Mr. Chairman, and these funds



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4 were made available out of provincial treasury only out
5 of what we call our dividend fund.

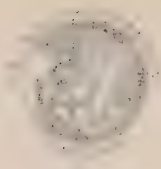
6 COMMISSIONER FIRESTONE: If you applied
7 to Central Mortgage and Housing Corporation, or the
8 appropriate bodies you have designated to act -- have
9 they applied to Central Mortgage and Housing Corporation
10 for funds to finance such programs? The advantage of
11 such an application would be that the very large amount
12 of federal funds would be made available which would
13 enable you to have the limited funds of the province go
14 much further, and you would build many more homes for
15 senior citizens using your contribution and that of the
16 provincial municipality and other groups. Have you
17 approached the Central Mortgage and Housing Corporation
18 for such a loan?

19 MR. ROGERS: I cannot answer that.

20 MR. HOMAN: The answer is no.

21 HON. DR. ROSS: We have not approached
22 them for this reason: that in the initial decision to
23 build these homes throughout the province, homes which
24 we built, placed at various strategic and major towns,
25 to accommodate 50 people, what we felt was going to be
26 enough, at the present time they are occupied about 80%
27 to 85% of their occupancy.

28 Now, in the future what these Foundations
29 will want to do, no doubt, is perhaps build some house-
30 keeping units so that a couple may wish to have a little
housekeeping unit. The acreage that was required for
the site was five acres, so it would be adequate to build
these along it.



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MR. ROBERTS: I cannot answer that.

MR. HOWARD: The answer is no.

MR. ROBERTS: We have not approached

them for this reason: that in the initial decision to build these homes throughout the province, homes which we built, placed at various strategic and major towns, to accommodate 50 people, what we felt was going to be enough, at the present time they are occupied about 44 to 55% of their occupancy.

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will want to do, no doubt, is perhaps build some more keeping units so that a couple may wish to have a little horsekeeping unit. The acreage that was required for the site was five acres, so it would be adequate to build these along it.



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3 Whether they will wish to approach
4 Central Mortgage and Housing Corporation for loans in
5 this respect -- they are a corporate body that would
6 have authority to borrow, so they might wish to do this;
7 although what they are planning, I think, is out of their
8 own resources. They charge \$60 a week for board and
9 room in these places, or \$65. They hope that perhaps
10 with some profits and perhaps some municipal funds, as
11 well as the voluntary efforts of service clubs in the
12 region, that they can make this a pay-as-you-go deal,
13 rather than extend it over a 25-year period, by which
14 time the thing would have cost them twice as much as it
is costing now.

15 COMMISSIONER FIRESTONE: I take it, sir,
16 that Alberta experiences a similar situation as other
17 provinces, and that is the aging process. You will have
18 more senior citizens, and if you only have a certain
19 amount of money for homes and housekeeping units for
20 these senior citizens, would not the limited funds
21 of the citizens of Alberta go further if you only made
22 a contribution of 25% and obtained 75% at lower than the
23 interest rate to finance such a program, assuming there
24 is a demand for it, and assuming you have more and more
25 senior citizens from year to year. And, furthermore,
26 there may be some economic advantages as far as your
27 hospitalization program is concerned if there is an
28 opportunity of persuading people to go back to their
29 homes, or perhaps with some home care you may reduce
30 the pressure on your limited hospital facilities.

HON. DR. ROSS: We feel that probably

Whether they will wish to approach Central Mortgage and Housing Corporation for loans in this respect -- they are a corporate body that would have authority to borrow, so they might wish to do this; although what they are planning, I think, is out of their own resources. They charge \$60 a week for board and room in these places, or \$65. They hope that perhaps with some profits and perhaps some municipal loans, as well as the voluntary efforts of service clubs in the region, that they can make this a pay-as-you-go deal, rather than extend it over a 25-year period, by which time the thing would have cost them twice as much as it is costing now.

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1104. DT. 8033: We feel that probably



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3 our hospital facilities are not so limited at the present
4 time that we are concerned about it. We will probably
5 have to be concerned about it in the future, and are.

6 THE CHAIRMAN: Dr. Ross, you mentioned
7 people participating on a means test.

8 HON. DR. ROSS: Yes, for medical
9 services.

10 THE CHAIRMAN: Have you found in your
11 experience that there is resentment to a means or a needs
12 test as is suggested on a patient?

13 HON. DR. ROSS: This Mr. Rogers would
14 know better than I, because we have -- we only have one
15 program and that is our diabetic program, as mentioned
16 in our brief. We use a sort of means test to see whether
17 they come under it. But in welfare, I don't know that
18 you have had a great deal of resentment to them displaying
19 what assets they have.

20 THE CHAIRMAN: It has been represented
21 to us that it is degrading, demoralizing -- this and
22 that and the other thing. What is your experience?

23 HON. DR. ROSS: I think they must be
24 very sensitive people.

25 MR. ROGERS: As public welfare is, by
26 definition, a program based on need, public welfare, at
27 least in Alberta, does not have a program which is not
28 governed by needs or means tests.

29 THE CHAIRMAN: Do you mean to imply that
30 if a person comes to public welfare that that person
does not feel degraded by doing so?

MR. ROGERS: Well, I do not imagine

our hospital facilities are not so limited at the present time that we are concerned about it. We will probably have to be concerned about it in the future, and now.

THE CHAIRMAN: Mr. Ross, you mentioned

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MR. ROSS: Well, I do not imagine



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3 anybody feels that coming to public welfare is a pleasure.
4 It is something which is forced on them by circumstances.

5 COMMISSIONER FIRESTONE: When someone
6 comes to your Department, does he have to fill out a
7 form showing what is his income and assets?

8 MR. ROGERS: Yes.

9 COMMISSIONER FIRESTONE: So there is a
10 means test in effect?

11 MR. ROGERS: Yes.

12 COMMISSIONER FIRESTONE: Thank you.

13 HON. DR. ROSS: If he could pay, he
14 would not be there. If he is there, he should be pre-
15 pared to indicate what resources he has to care for
16 himself.

17 THE CHAIRMAN: I don't know what the
18 experience in Alberta is, but elsewhere we do hear the
19 representation that there is something degrading -- it
20 is a bad word: "the means test".

21 HON. DR. ROSS: I am afraid I am from
22 the old school, and I would not agree.

23 MR. FRAWLEY: Mr. Chairman, I have
24 handed in an erratum sheet, and I would particularly
25 call attention to item No. 6 which refers to page 44 of
26 the brief and requires the insertion of a revised table.
27 I have also handed that in. The little revised sheet
28 goes along with the erratum sheet.

29 One more thing I would like to ask you
30 to add, and that is a twelfth item at the bottom of the
erratum sheet, please, and that reference is simply at
page 86 in the second last line: "\$4.75 for 100 tablets"

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MR. KRAWLEY: Mr. Chairman, I have

handed in an erratum sheet, and I would particularly

call attention to item No. 8 which refers to page 4 of the brief and requires the insertion of a revised table.

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goes along with the erratum sheet.

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to add, and that is a twelfth item at the bottom of the

erratum sheet, please, and that reference is simply to

page 56 in the second last line: "\$4.75 for 100 tablets"



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3 should be "\$4.75 for 50 tablets".

4 Now, I have been told by Mr. Lafrance,
5 Mr. Chairman, that our brief is Exhibit 112, and in
6 the course of the section dealing with the cost of
7 drugs there are four exhibits which are to be offered
8 to the Commission, and I will turn up the page or simply
9 refer to it.

10 The first one is on page 81 and there
11 I would like to tender to the Commission one copy each
12 of the English and French texts of what has come to be
13 known as the Green Book. It is the statement on material
14 relating to the manufacture and distribution and sale of
15 drugs by the Director of Investigation and Research,
16 Combines Investigation Act, which was tabled by the
17 Minister of Justice in June last.

18 --- EXHIBIT NO. 112A: Statement on material relating to
19 the manufacture, distribution and
20 sale of drugs.

21 --- EXHIBIT NO. 112B: French copy of same.

22 The French copy is much thicker, but
23 that is only because the typing is on one side of the
24 sheet.

25 Then, on page 82, which is the next page,
26 the references at the bottom of the page in paragraph 291.
27 We are offering as an exhibit to this Commission a copy
28 of the submission which we made to the Restrictive Trade
29 Practices Commission in its inquiry into the manufacture,
30 distribution and sale of drugs.



should be "54.75 for 50 tablets".

Now, I have been told by Mr. Lattance,

Mr. Chairman, that our brief is Exhibit 112, and in

the course of the session dealing with the cost of

drugs there are four exhibits which are to be referred

to the Commission, and I will turn up the page or pages

refer to it.

The first one is on page 81 and there

I would like to refer to the Commission one copy each

of the English and French texts of what has come to be

known as the Green Book. It is the statement on matters

relating to the manufacture and distribution and sale of

drugs by the Director of Investigation and Research,

Combined Investigation Unit, which was tabled by the

Minister of Justice in June last.

--- EXHIBIT NO. 112: Statement on matters relating to
the manufacture, distribution and
sale of drugs.

--- EXHIBIT NO. 113: French copy of same.

The French copy is also there, but

that is only because the typing is on one side of the

Then, on page 82, which is the next page,

the references at the bottom of the page in paragraph 10.

We are offering as an exhibit to this Commission a copy

of the submission which we made to the Resolutions Committee

of the Commission in its capacity as the manufacturer,

distribution and sale of drugs.



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3 --- EXHIBIT NO. 112C: Submission to the Restrictive
4 Trade Practices Commission by
the Government of Alberta.
5

6 And then on page 85 of the brief, there
7 is a reference to what is called a statement showing the
8 costs and prices of a representative number of drugs in
9 each of three groups which have been selected, and I
would offer this statement as an exhibit.
10

11 --- EXHIBIT NO. 112D: Statement showing the costs and
12 prices of a representative number
of drugs in each of three groups:
13 (antibiotic, corticosteroid and
tranquilizer drugs) filed by the
Government of Alberta.

14 Then, there is one more exhibit, and
15 the reference to that is on page 104, and there we offer
as an exhibit a copy of the Formulary of the University
16 of Alberta Hospital.
17

18 --- EXHIBIT NO. 112E: Copy of the Formulary of the
19 University of Alberta Hospital,
1958.

20 Now, those are all of the exhibits, and
21 what we propose, sir, is to confine ourselves, if that
22 is agreeable, to a reading by Dr. Ross of pages 112,
23 113, 114 and 115, which are called "Summary, Conclusions
and Recommendations", if that is satisfactory.
24

25 HON. DR. ROSS: On page 81, you will
26 notice that the members of our Legislature a year ago
were concerned about the problem of the cost of drugs
27 to the people of Alberta and introduced a resolution on
28 Private Members' Day and had a debate, which I think had
29 unanimous endorsement and was submitted to the Federal
30



--- EXHIBIT NO. 1120: Submission to the Representative
Trade Practices Commission by
the Government of Alberta.

And then on page 85 of the paper, there
is a reference to what is called a statement showing the
costs and prices of a representative number of drugs in
each of three groups which have been selected, and I
would offer this statement as an exhibit.

--- EXHIBIT NO. 1121: Statement showing the costs and
prices of a representative number
of drugs in each of three groups.

translating drugs) filed by the
Government of Alberta.
Then, there is one more exhibit, and
the reference to that is on page 114, and there we offer
as an exhibit a copy of the formulary of the University
of Alberta Hospital.

--- EXHIBIT NO. 1122: Copy of the formulary of the
University of Alberta Hospital.

Now, those are all of the exhibits, and
what we propose, sir, is to examine ourselves, if that
is agreeable, to a reading by Mr. Ross of pages 112,
113, 114 and 115, which are called "Summary, Conclusions

107. DR. ROSS: On page 85, you will
notice that the members of our Legislature a year ago
were concerned about the problem of the cost of drugs
to the people of Alberta and introduced a resolution on
Private Members' Day and had a debate, which I think had
unanimous endorsement and was submitted to the Federal



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4 Government for consideration, since we have no pharmaceu-
5 tical houses in Alberta, and because of this it was
6 felt that a submission should be made by our Government
7 to the Restrictive Trade Practices Commission. That is
8 one of the exhibits which you have.

9 When the decision was made to present
10 a brief to your Commission, sir, it was felt that we
11 would not be doing full justice to this report if we
12 did not include some of our concern about this particular
13 problem because we do feel that it has an impact on the
14 cost of health services, not only to the people of
15 Alberta but to the people of Canada as well.

16 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

17 371. There is serious reason to believe
18 that there is too great a spread between the manufacturer's
19 cost of prescription drugs and the price which the public
20 must pay. We have given examples of those spreads. The
21 magnitude of the spread indicates that competition -
22 price competition at the retail level does not exist or
23 does not operate effectively. Whether the spread is
24 accounted for by excessive marketing expense or excessive
25 profits or both can only be determined after the examina-
26 tion of the manufacturer's costs and profits which we
27 ask the Commission to make. The cost-revenue analysis
28 which we urge the Commission to make must be directed to
29 each of a representative number of prescription drugs.
30 An analysis of the cost-revenue position of the entire
business of the corporation would be valueless to deter-
mine the reasonableness or otherwise of the retail price
of the so-called "high priced" prescription drugs.



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Government for consideration, since we have no pharmaceutical houses in Alberta, and because of this it was felt that a submission should be made by our Government to the Restrictive Trade Practices Commission. That is one of the exhibits which you have.

When the decision was made to present a brief to your Commission, sir, it was felt that we would not be doing full justice to this report if we did not include some of our concern about this problem because we do feel that it has an impact on the cost of health services, not only to the people of Alberta but to the people of Canada as well.

SUMMARY OF FINDINGS AND RECOMMENDATIONS

1. There is a serious problem to believe that there is too great a spread between the manufacturing cost of prescription drugs and the price which the public must pay. We have given examples of those spreads. The magnitude of the spread indicates that competition in price competition at the retail level does not exist and does not operate effectively. Whether the spread is accounted for by excessive marketing expense or excessive profits or both can only be determined after the examination of the manufacturer's costs and profits which we ask the Commission to make. The cost-revenue analysis which we urge the Commission to make must be directed to each of a representative number of prescription drugs. An analysis of the cost-revenue position of the entire business of the corporation would be valueless to determine the reasonableness or otherwise of the retail price of the so-called "high priced" prescription drugs.



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4 372. The United States experience of
5 one leading manufacturer reveals that 49 cents of every
6 dollar spent for prescription drugs went to the retail
7 pharmacist and the wholesaler. This Commission must
8 examine the profitability or otherwise of the sale of
9 prescription drugs by wholesale and retail. Such examina-
10 tion must be directed separately to the retail pharmacist
11 with a small volume of prescription business and the
12 dispensary type pharmacist enjoying by reason of location
13 a heavier concentration of prescription business. Inves-
14 tigation and analyses of this kind will enable the Commis-
15 sion to conclude whether or not too great a share of the
16 consumer's prescription dollar is absorbed in wasteful or
17 otherwise uneconomic marketing at the wholesale and
18 retail levels.

19 373. If the investigation by the
20 Commission of the cost-revenue position of the manufac-
21 turing and the marketing segments of the drug industry
22 disclose unwarranted expense or excessive profits, ways
23 and means must be devised to require that such costs be
24 eliminated and to assure that in the public interest the
25 consumer price of prescription drugs reflects such elimi-
26 nation. A special federal agency should be given a
27 continuing authority to examine from time to time the
28 revenue-cost position of prescription drugs. The exis-
29 tence of such powers of itself without resort to price
30 fixing or control in the nature of public utility control
would have a beneficial deterrent effect. The justifica-
tion for setting up a federal agency with investigatory
powers such as we have indicated is wholly justifiable



372. The United States experience of one leading manufacturer reveals that 19 cents of every dollar spent for prescription drugs went to the retail

examine the profitability or otherwise of the sale of prescription drugs by wholesale and retail. Such examination must be directed separately to the retail pharmacist with a small volume of prescription business and the dispensary type pharmacist enjoying by reason of location a heavier concentration of prescription business. Investigation and analysis of this kind will enable the Commission to conclude whether or not too great a share of the consumer's prescription dollar is absorbed in wasteful or otherwise uneconomic marketing at the wholesale and retail levels.

373. If the investigation by the Commission of the cost-revenue position of the manufacturing and the marketing segments of the drug industry disclosed unwarranted expense or excessive profitability and means must be devised to require that such costs be eliminated and to assure that in the public interest the consumer price of prescription drugs reflects such elimination. A special federal agency should be given a continuing authority to examine from time to time the revenue-cost position of prescription drugs. The exercise of such powers of itself without resort to any fixing or control in the nature of public utility control would have a beneficial deterrent effect. The justification for setting up a federal agency with investigatory powers such as we have indicated is wholly justified



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4 in the light of the evidence that there is no price
5 competition at the retail level and as a concomitant,
6 the high retail prices subsidize the low prices to
7 volume institutional purchasers.

8 374. It is our view that the existence
9 of such a body with cost finding - not price fixing
10 powers would beneficially affect the high level of
11 retail prices - prices which are established not by the
12 retail pharmacist but by the manufacturer.

13 375. There might well be added to the
14 powers of the federal agency above referred to, the
15 powers and functions described by the Canadian manager
16 of Lederle. Referring to the burden of the cost of promo-
17 ting and marketing prescription drugs Mr. Ralph B.
18 Thompson said:

19 "--- we would be in favour of an
20 official bulletin or other regular
21 publication designed to acquaint
22 doctors and hospitals and drug purcha-
23 sing agencies with information on the
24 latest developments in the drug industry.
25 We feel that such a publication is, in
26 fact, long overdue and we would be
27 prepared to give active support to its
28 publication".

29 376. These views of the Lederle Company
30 are quite in line with our own recommendation to the
Restrictive Trade Practices Commission during the course
of its inquiry into the manufacture, distribution and
sale of drugs. We said at page 5 of our Brief:



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4 "It is suggested that the Commission
5 should look into ---- a proposal that
6 the medical profession or a disinterested
7 body periodically publish a release to
8 the practising physician covering the
9 advantages and disadvantages of new or
10 modified drugs or combinations, but
11 in terms uncoloured by sales promotion".
12 377. We favor the more widespread use
13 of generic name drugs - to the point of recommending
14 appropriate amendments to existing legislation which
15 would extend to the retail pharmacist the discretion now
16 exercised by the hospital pharmacist resulting from the
17 adoption of the hospital formulary system. The retail
18 pharmacist should have the right to dispense a generic
19 equivalent for a brand name drug ordered by the physician
20 unless the latter specifies that only the brand name drug
21 be dispensed. We feel that the evidence submitted to
22 this Commission and to the Restrictive Trade Practices
23 Commission relating to the substantial differences in
24 price between brand name drugs and their generic equiva-
25 lents warrants the most earnest efforts being made to
26 bring those price benefits to the consumer. It is our
27 view also that any fears that generic drugs which
28 admittedly in many instances are imported into Canada
29 from foreign countries are not quality products can be
30 dispelled through the operation of the Regulations made
under The Federal Food and Drugs Act, either as such
regulations presently exist or as they may require to
be altered to suit the circumstances.



"It is suggested that the Commission should look into ---- a proposal that the medical profession or a disinterested body periodically publish a release to the practising physician covering the advantages and disadvantages of new or modified drugs or combinations, but in terms uncoloured by sales promotion". 377. We favor the more widespread use of generic name drugs - to the point of recommending appropriate amendments to existing legislation which would extend to the retail pharmacist the discretion now exercised by the hospital pharmacist resulting from the adoption of the hospital formulary system. The retail pharmacist should have the right to dispense a generic equivalent for a brand name drug ordered by the physician unless the latter specifies that only the brand name drug be dispensed. We feel that the evidence submitted to this Commission and to the Restrictive Trade Practices Commission relating to the substantial differences in price between brand name drugs and their generic equivalents warrants the most earnest efforts being made to bring those price benefits to the consumer. It is our view also that any fears that generic drugs which admittedly in many instances are imported into Canada from foreign countries are not quality products can be dispelled through the operation of the Regulations made under the Federal Food and Drugs Act, either as such regulations presently exist or as they may require to be altered to suit the circumstances.



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4 378. It is our view and our recommenda-
5 tion that The Patent Act must not stand in the way of
6 efforts to reduce the price of prescription drugs. To
7 illustrate: on page 7 of this submission we described
8 the cost-price situation for Smith, Kline & French
9 Stelazine. Tablets costing SKF \$1.15 per 1,000 are
10 listed at retail prices equivalent to \$95.00 per 1,000.
11 If the right to price Stelazine to the public at the
12 prices indicated is derived from the existence of
13 Canadian patent rights held by the United States parent
14 of SKF, then it well might be advisable to assign to
15 the special federal agency which we have discussed in
16 the immediately preceding paragraphs powers to determine
17 whether undue advantage of patent rights is being taken
18 in terms of the list prices established.

17 379. In sum it is our submission:-

18 (1) that the Commission must find that
19 the price of drugs to the consumer purchasing at retail
20 at prices established by the manufacturer is excessively
21 high as a result of some or all of the following:

- 22 - the wasteful and costly promotion
23 and marketing practices of the manufac-
24 turer;
- 25 - excessive profits;
- 26 - the practice of large discounts for
27 volume purchases by public buyers;
- 28 - the absence of price competition
29 among the manufacturers in the supplying
30 of the retail pharmacist and through
him the public;



378. It is our view and our recommendation-

tion that The Patent Act must not stand in the way of efforts to reduce the price of prescription drugs. To illustrate: on page 7 of this submission we described the cost-price situation for Smith, Kline & French Stealzine. Tablets costing \$21.15 per 1,000 are listed at retail prices equivalent to \$55.00 per 1,000. If the right to price Stealzine to the public at the prices indicated is derived from the existence of Canadian patent rights held by the United States parent of SKT, then it will right be advisable to assign to the special federal agency which we have discussed in the immediately preceding paragraph powers to determine whether undue advantage of patent rights is being taken in terms of the list prices established.

379. In sum it is our submission -

(1) that the Commission must find that the price of drugs to the consumer purchasing at retail at prices established by the manufacturer is excessively high as a result of some or all of the following:

- the wasteful and costly promotion and marketing practices of the manufacturer;
- excessive profits;
- the practice of large discounts for volume purchases by public buyers;
- the absence of price competition among the manufacturers in the supplying of the retail pharmacist and through him the public;



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4 - the limited availability of lower
5 priced generic drugs for the filling
6 of prescriptions at the retail level.

7 (2) that the Commission must devise
8 means to reduce the high price of drugs sold at retail.

9 (3) that The Patent Act and The Food
10 and Drugs Act and its Regulations must be examined to
11 determine the extent, if any, to which such statutes
12 and regulations contribute - positively or negatively -
13 to the high price of prescription drugs at retail.

14 (4) that with a view to combating the
15 high cost of drugs, the Commission should recommend the
16 setting up of a federal agency with power and direction -

17 (i) to examine the revenue-cost posi-
18 tion of individual drugs so as to
19 determine the costs as well as profits
20 of manufacturing and marketing;

21 (ii) to serve as a source of informa-
22 tion for physicians, pharmacists, hospi-
23 tals and others concerning new drugs,
24 modifications and combinations, so as to
25 eliminate or moderate the present cost
26 to manufacturers of bringing such drugs
27 to the attention of the people concerned;

28 (iii) to encourage, in the interest of
29 price savings, the widest use of quality
30 generic drugs by physicians and retail
pharmacists.

(iv) to assure that The Patent Act,
The Food and Drugs Act or any other



- the limited availability of lower priced generic drugs for the filling of prescriptions at the retail level.

(2) that the Commission must devise means to reduce the high price of drugs sold at retail.

(3) that The Patent Act and The Food and Drug Act and its regulations must be examined to determine the extent, if any, to which such statutes and regulations contribute - positively or negatively - to the high price of prescription drugs at retail.

(4) that with a view to combating the high cost of drugs, the Commission should recommend the setting up of a federal agency with power and direction -

(i) to examine the revenue-cost position of individual drugs so as to determine the costs as well as profits of manufacturing and marketing;

(ii) to serve as a source of information for physicians, pharmacists, hospitals and others concerning new drugs, modifications and combinations, so as to eliminate or moderate the present cost of manufacturers or bringing such drugs to the attention of the people concerned;

(iii) to encourage, in the interest of price savings, the widest use of quality generic drugs by physicians and retail pharmacists.

(iv) to assure that The Patent Act, The Food and Drug Act or any other



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4 legislation does not stand in the way
5 of any steps which might be taken to
6 reduce the cost of drugs.

7 THE CHAIRMAN: Thank you, Dr. Ross.

8 MR. FRAWLEY: In addition to putting
9 into the record the three or four pages of summary I
10 thought that I might call attention, very briefly, to
11 the price statement, Exhibit 112B; that exhibit pretty
12 well speaks for itself. This is a selection of the
13 three main groups of prescription drugs, the antibiotics,
14 the corticosteroids and the tranquilizers. I should
15 like to ask you to look at page 2 to give you an idea
16 of the scope of the exhibit. The exhibit endeavours
17 to give for each drug, first, the generic name with the
18 dosage form; the brand name and the second brand name
19 if there is more than one; then the manufacturer's cost,
20 which as I was about to say a moment ago, is admittedly
21 taken from the Green Book. Then there is the list price
22 and the price to the retail pharmacist and the price to
23 the wholesaler. That group of prices is taken from the
24 manufacturer's catalogues or from a document that is
25 widely in use in Canada called the Price List which is
26 published under the aegis of the Canadian Pharmaceutical
27 Journal. Then, column 7 is the price to the University
28 Hospital in Edmonton. That is, as the Commission might
29 suppose, information derived from the University Hospital.
30 Then there follows three columns, Starkman, Gilbert and
 Empire. We thought it well to put in that group of the
 people who held themselves out to sell drugs by their
 generic names; there may be others but these are the



legislation does not stand in the way
of any steps which might be taken to

THE CHAIRMAN: Thank you, Dr. Ross.
MR. TRAWLEY: In addition to putting

into the record the three or four pages of summary I
thought that I might call attention, very briefly, to
the price statement, Exhibit 11B; that exhibit pretty
well speaks for itself. This is a selection of the
three main groups of prescription drugs, the antibiotics,
the corticosteroids and the tranquilizers. I should
like to ask you to look at page 2 to give you an idea
of the scope of the exhibit. The exhibit endeavors
to give for each drug, first, the generic name with the
dosage form; the brand name and the second brand name
if there is more than one; then the manufacturer's cost,
which as I was about to say a moment ago, is admittedly
taken from the Green Book. Then there is the list price
and the price to the retail pharmacist and the price to
the wholesaler. That group of prices is taken from the
manufacturer's catalogues or from a document that is
widely in use in Canada called the Price List which is
published under the aegis of the Canadian Pharm-chemical
Journal. Then, column 7 is the price to the University
Hospital in Edmonton. That is, as the Commission might
suppose, information derived from the University Hospital.
Then there follows three columns, Starkman, Gilbert and
Smith. We thought it well to put in that group of the
people who held themselves out to sell drugs by their
generic names; there may be others but these are the



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3 best-known ones, these are the ones that came before the
4 Restrictive Trade Practices Commission.

5 With regard to antibiotics there is a
6 rather complete story to the extent that the manufactu-
7 rer's cost is shown in each case. When you come to
8 corticosteroids, which is to be found on pages 4 and 5,
9 there is no manufacturer's cost because it happens that
10 the Department of Justice inquiry did not go into corti-
11 costeroids; they dealt with antibiotics, tranquilizers
12 and vitamin preparations as I recall. We were able to
13 indicate some manufacturer's costs and you will find
14 that in a footnote on page 5 and that was taken, quite
15 admittedly, from the proceedings of what is known as the
16 Kefauver Committee in the United States and that is why
17 you find in column 3 the reference to the footnote which
18 says that in the United States it was found that the cost
19 of producing - they certainly are referring to Schering's
20 Prednisone, one-and-a-half cents a tablet or less.

21 Then, passing to tranquilizers, there
22 we find a further column that we were anxious to give to
23 the Commission. Tranquilizers start on page 6 and cover
24 pages 6, 7 and 8 and there is a column 11 and that is
25 the price to the provincial mental institutions in
26 Alberta. All those are set out to give you an idea of
27 the spread not only between the cost and the list price
28 but the spread between the list price and the price, for
29 instance, which our provincial mental hospitals pay. So,
30 again, the statement shows the spread between the price
which the retail pharmacist pays and the price which the
provincial mental hospital pays.



best-known ones, these are the ones that came before the

With regard to antipsychotics there is a

rather complete story to the extent that the manufacturer's

cost is shown in each case. When you come to

carbamazepine, which is to be found on pages 4 and 5,

there is no manufacturer's cost because it happens that

the Department of Justice inquiry did not go into carbamazepine

and vitamin preparations as I recall, we were able to

indicate some manufacturer's costs and you will find

that in a footnote on page 5 and that was taken, quite

relatives Committee in the United States and that is why

you find in column 3 the reference to the footnote which

says that in the United States it was found that the cost

of producing - they certainly are referring to Schering's

prednisone, one-and-a-half cents a tablet or less.

we find a further column that we were anxious to give to

the Commission. Transmittals sent on page 6 and cover

pages 6, 7 and 8 and there is a column 11 and that is

the price to the provincial mental institutions in

Alberta. All those are set out to give you an idea of

the spread not only between the cost and the list price

but the spread between the list price and the price, for

instance, which our provincial mental hospitals pay. So,

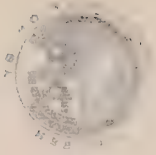
again, the statement shows the spread between the price

which the retail pharmacist pays and the price which the

provincial mental hospital pays.



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4 It also shows the difference in the
5 price which the retail pharmacist pays and a hospital
6 like the University Hospital pays.
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8 You will find, incidentally, that
9 looking at page 4, for instance, you will find in
10 column 7, the initials H.P.; now, that refers to the
11 hospital price list because the manufacturers publish
12 a special list for the hospitals. Wherever the notation
13 "H.P." appears, that means that the University there is
14 buying according to the hospital list. Then again the
15 University Hospital also from time to time calls for
16 tenders and I should direct the Commission's attention
17 to the fact that Appendix B is a memorandum covering the
18 tenders. That memorandum is divided into two sections,
19 Section A dealing with the University of Alberta Hospital
20 and Section B which deals with the tenders of the Depart-
21 ment of Public Health. The information is fairly self-
22 explanatory and it indicates the benefit that goes to a
23 large purchaser, a government department or a hospital
24 when they put aside for the time being the hospital price
25 list and ask the manufacturers to give them quotations
26 for large quantities. I will not take the time of the
27 Commission because the information is set out in fairly
28 complete detail. I think there is nothing else that I
29 would like to call your attention to particularly except
30 perhaps you might look, and I am sure you have already
looked, at the two charts, one of which follows page 90
and one which follows page 92. These were charts which
were taken just as you see them from the records of the
Kefauver Committee and which are, of course, the American



It also shows the difference in the price which the retail pharmacist pays and a hospital like the University hospital pays.

Looking at page 4, for instance, you will find in hospital price list because the manufacturers publish a special list for the hospitals. Whenever the notation "H.P." appears, that means that the University there is buying according to the hospital list. Then again the University hospital also from time to time calls for tenders and I should like to draw the Commission's attention to the fact that Appendix 2 is a memorandum covering the tenders. That memorandum is divided into two sections, Section A dealing with the University of Alberta Hospital and Section B which deals with the tenders of the Department of Public Health. The information is fairly self-explanatory and it indicates the benefit that goes to a large purchaser, a government department or a hospital when they put aside for the time being the hospital price list and ask the manufacturers to give them quotations for large quantities. I will not take the time of the Commission because the information is set out in fairly complete detail. I think there is nothing else that I would like to call your attention to particularly except perhaps you might look, and I am sure you have already looked, at the two charts, one of which follows page 30 and one which follows page 32. These were charts which were taken just as you see them from the records of the Refresher Committee and which are, of course, the American



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3 experience. They indicate the size of the gross margin,
4 the margin between the full cost of the drug and the
5 cost which the druggist pays for it. In the chart
6 which follows page 90 there has been no indication of
7 the further higher price which the prescription holder
8 pays; it is limited to the gross margin between the cost
9 and the price which the druggist pays.

10 Then, the chart which follows page 92,
11 which is the experience of the Lederle division of the
12 American Cyanamid Company; there you will see their
13 experience is that retailer and wholesaler in 1958 took
14 48¢ of the prescription dollar and the manufacturer took
15 51¢. I say "prescription" and probably the record should
16 be checked because it could be that these drugs include
17 what are called over-the-counter drugs as well as pres-
18 cription drugs. In any event, there is the breakdown.

19 Now, I think in view of the fact there
20 is to be no attempt to read the whole brief that probably
21 that will give the Commission just the merest idea of
22 what we were trying to do. Perhaps I should say in a
23 word what we are trying to do is indicate our own complete
24 inability to run this matter down but we do say, contrary
25 to us, that the Commission has the unlimited right and I
26 was going to say unlimited resources, to find out the
27 things that we could not find out even if we had
28 unlimited resources because it is in a field over which
29 we have no jurisdiction.

30 THE CHAIRMAN: Thank you, Mr. Frawley,
and also for the compliment that we have unlimited
resources. This matter of the price of drugs is one

experience. They indicate the size of the gross margin, the margin between the full cost of the drug and the cost which the druggist pays for it. In the chart which follows page 80 there has been no indication of the further higher price which the prescription holder pays; it is limited to the gross margin between the cost and the price which the druggist pays.

Then, the chart which follows page 81,

which is the experience of the Federal Division of the American Cyanamid Company; there you will see their experience is that retailer and wholesaler in 1958 took 44¢ of the prescription dollar and the manufacturer took 51¢. I say "prescription" and probably the record should be checked because it could be that those drugs include what are called over-the-counter drugs as well as prescription drugs. In any event, there is the breakdown. Now, I think in view of the fact there

is to be no attempt to read the whole brief that probably that will give the Commission just the most idea of what we were trying to do. Perhaps I should say in a word that we are trying to do is indicate our own complete inability to run this matter down but we do say, contrary to us, that the Commission has the unlimited right and I was going to say unlimited resources, to find out the things that we could not find out even if we had unlimited resources because it is in a field over which we have no jurisdiction.

THE CHAIRMAN: Thank you, Mr. Trawley,

and also for the comment that we have unlimited resources. This matter of the price of drugs is one



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3 that has been referred to periodically in our hearings
4 in several provinces and there is no denying that it is
5 one in which there is a considerable amount, a great
6 deal, of public interest. I think we would like some
7 information, some help from you on one or two aspects
8 at the moment because this is a matter that is receiving
9 our careful and continued attention. What is your view
10 as to the legislative competence of the Parliament of
11 Canada to regulate the price of drugs?

12 MR. FRAWLEY: At the moment I have been
13 somewhat careful to not say that there should be public
14 utility control of drugs but I do submit that it is
15 within the competence of Parliament to set up an agency,
16 and it might indeed be the Food and Drug Directorate with
17 added powers, to examine the cost revenue position. I
18 cannot put our position any simpler than that. I think
19 you must know what goes into the difference between the
20 price which the prescription patient pays and the cost
21 of the drug to the manufacturer whether he makes it or
22 whether, as he does in large part, he imports it; he
23 imports it and then formulates it in Canada which is
24 roughly the pattern.

25 I see no question as to the constitu-
26 tional position there; it is inter-provincial trade, it
27 would take it immediately out of the purview of the
28 province; it is inter-provincial trade and it is just as
29 much business of the Food and Drug Directorate or some
30 other agency which has the powers which the Food and
Drug agency now exercises. I quite agree they are doing
that now under the Police Board as a principle of

that has been referred to periodically in our hearings in several provinces and there is no denying that it is one in which there is a considerable amount, a great deal, of public interest. I think we would like some information, some help from you on one or two aspects at the moment because this is a matter that is receiving our careful and continued attention. What is your view as to the legislative competence of the Parliament of Canada to regulate the price of drugs?

MR. LAWLEY: At the moment I have been

somewhat careful to not say that there should be public utility control of drugs but I do submit that it is within the competence of Parliament to set up an agency, and it might indeed be the Food and Drug Directorate with added powers, to examine the cost revenue position. I cannot put our position any stronger than that. I think you must know what goes into the difference between the price which the prescription patient pays and the cost of the drug to the manufacturer whether he makes it or whether, as he does in large part, he imports it; he imports it and then formulates it in Canada which is roughly the pattern.

I see no question as to the constitutional position there; it is inter-provincial trade, it would take it immediately out of the control of the province; it is inter-provincial trade and it is just as much business of the Food and Drug Directorate on some other agency which has the powers which the Food and Drug agency now exercises. I quite agree they are doing that now under the Police Board as a principle of



1 criminal law. I think that would be the basic jurisdiction,
2 the constitutional jurisdiction.

3 MR. FRAWLEY: But I see no reason why and, in fact, I
4 would go so far as to say, there wouldn't be any contest.
5 I would say there wouldn't be any contest. I venture the
6 respectful submission; if this Commission said to Cyanamid
7 of Canada, "We would like to know precisely how much has
8 gone into the various items in your spread, how much has
9 gone into research, how much has gone into advertising of
10 the various kinds, how much has gone into taxes, insurance
11 and profits", that that information would be forthcoming.
12 I think they would decline to put it on public record
13 as they did decline to put it on the public record
14 before the Restrictive Trade Practices Commission.

15 THE CHAIRMAN: They did decline to do
16 that before the Restrictive Trade Practices Commission?

17 MR. FRAWLEY: Yes. I personally gave
18 them an opportunity and I asked them to put it on the
19 record. I knew what the answer was before I asked the
20 question. They said, no, no. They wouldn't do that
21 for the obvious reasons that their competitors would
22 know just how much money they were spending on detailmen,
23 which some people think takes up a lot of money.

24 THE CHAIRMAN: Mr. Frawley, if they
25 wouldn't do it for one investigating body, why do you
26 think they would be more favourable to this Commission?

27 MR. FRAWLEY: I should have completed
28 what I said. The witness did refuse to put the informa-
29 tion on the public record. He said that he would
30 certainly give it to the Restrictive Trade Practices
Commission, and for all I know it may now be in the
possession of the Restrictive Trade Practices Commission.
There was no question about that at all.



Fraser

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2 the constitutional jurisdiction.
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4 MR. FRASER: But I see no reason why and, in fact, I
5 would go so far as to say, there wouldn't be any contest.
6 I would say there wouldn't be any contest. I venture the
7 respectful submission; if this Commission said to the
8 of Canada, "We would like to know precisely how much has
9 gone into the various items in your spread, how much has
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11 the various kinds, how much has gone into taxes, insurance
12 and profits", that that information would be forthcoming.
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14 as they did decline to put it on the public record
15 before the Restrictive Trade Practices Commission.
16 THE CHAIRMAN: They did decline to go
17 that before the Restrictive Trade Practices Commission?
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20 record. I know that the answer was before I asked the
21 question. They said, no, no. They wouldn't do that
22 for the obvious reasons that their competitors would
23 know just how much money they were spending on details,
24 which some people think takes up a lot of money.
25 THE CHAIRMAN: Mr. Fraser, if they
26 wouldn't do it for one investigating body, why do you
27 think they would be more favourable to this Commission?
28 MR. FRASER: I should have completed
29 what I said. The witness did refuse to put the information on the public record. He said that he would
30 certainly give it to the Restrictive Trade Practices
31 Commission, and for all I know it may now be in the
32 possession of the Restrictive Trade Practices Commission.
33 There was no question about that at all.



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3 COMMISSIONER McCUTCHEON: He thought
4 that would preserve the confidential nature of the
5 information, Mr. Frawley?

6 MR. FRAWLEY: I did?

7 COMMISSIONER McCUTCHEON: Did he think
8 it?

9 MR. FRAWLEY: He did. He had no - he
10 didn't have any problem. I would think I would rather
11 go along with him there. I think if he filed that with
12 the Restrictive Trade Practices Commission it would be
13 confidential after that. The investigating officers
14 of the Combines Investigation Branch went out and picked
15 up a great deal of information which wasn't put into the
16 Green Book. I agree some people thought there was too
much put into the Green Book.

17 THE CHAIRMAN: Mr. Frawley, what good
18 is confidential information to this Commission?

19 MR. FRAWLEY: Well, I find it difficult
20 to disagree with you. I would rather...

21 THE CHAIRMAN: I am putting that very
22 seriously.

23 MR. FRAWLEY: I would rather see it on
the public record.

24 THE CHAIRMAN: Because if we are going
25 to transpose it into anything effective it has to be,
eventually, a matter of public record.

26 MR. FRAWLEY: Of course, you can go,
27 perhaps I should answer it, if you take any import of
28 the suggestion we have made there should be a continuing
29 body to police the cost revenue position and the
30

that would preserve the confidential nature of the

information, Mr. Frawley?

MR. FRAWLEY: I did.

MR. FRAWLEY: He did. He had no - he

didn't have any problem. I would think I would rather
go along with him there. I think if he filed that with
the Restrictive Trade Practices Commission it would be

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up a great deal of information which wasn't put into the
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MR. FRAWLEY: Well, I think it is difficult

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THE CHAIRMAN: I am getting that very

MR. FRAWLEY: I would rather see it on

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to transpose it into anything effective it has to be,

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MR. FRAWLEY: Of course, you can go,

perhaps I should answer it, if you take any import of

the suggestion we have made there should be a controlling

body to police the cost revenue position and the



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4 information given to you in confidence made you feel
5 that policing the cost revenue was a salutary thing then
6 it would have accomplished something there. It would
7 have accomplished there even though it wasn't put on the
8 public record. It was put before the Commission and the
9 Commission felt that there was enough, shall I say,
10 question, and I don't want to - I must not be accused
11 of going too far or making allegations at all. I
12 would like to be exceedingly modest. I say if you find
13 that there was something in the cost revenue position
14 which didn't contribute to the high cost of drugs, for
15 instance, that is why we selected what Lederle, what
16 the Cyanamid of Canada Company said which I thought was
17 rather a constructive suggestion and I was pleased to
18 see we made the same suggestion ourselves, that there
19 should be somebody to evaluate, and I think, perhaps,
20 what was said to you in Manitoba is not too far removed
21 from that, there should be somebody to evaluate drugs
22 with a view to removing the burden.

23
24 I think the Lederle representative felt
25 there was a burden. There is a lot of money spent. He
26 felt it had to be spent. There is a lot of money spent
27 in getting these drugs from the plant to the pharmacist
28 and to the doctor. I think he was making the suggestion
29 which he thought was a way of eliminating some of that
30 expense, even if only that were done it would be a helpful
thing.

31
32 THE CHAIRMAN: Mr. Frawley, if you
33 accept, as you may or may not, that approximately 5% of
34 the prescription drugs provided in Canada are manufactured



information given to you in confidence made you feel that policing the cost revenue was a salutary thing then it would have accomplished something there. It would have accomplished there even though it wasn't put on the public record. It was put before the Commission and the Commission felt that there was enough, shall I say, question, and I don't want to - I must not be accused of going too far or making allegations at all. I would like to be exceedingly modest. I say if you find that there was something in the cost revenue position which didn't contribute to the high cost of drugs, for instance, that is why we selected what we selected, what the Chairman of Canada Company said which I thought was rather a constructive suggestion and I was pleased to see we made the same suggestion ourselves, that there should be somebody to evaluate, and I think, perhaps, what was said to you in Montreal is not too far removed from that, there should be somebody to evaluate drugs with a view to removing the burden.

I think the tobacco representative felt there was a burden. There is a lot of money spent. He felt it had to be spent. There is a lot of money spent in getting these drugs from the plant to the pharmacist and to the doctor. I think he was making the suggestion which he thought was a way of eliminating some of that expense, even if only that were done it would be a helpful thing.

THE CHAIRMAN: Mr. Fraxley, if you

accept, as you may or may not, that approximately 1% of the prescription drugs provided in Canada are manufactured



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3 in Canada; whether that is a relatively correct figure...

4 MR. FRAWLEY: It is hard to know what
5 it is, but it is small.

6 THE CHAIRMAN: It is small.

7 MR. FRAWLEY: Very small.

8 THE CHAIRMAN: 95% then are imported.
9 Can you offer any suggestion as to how this Commission
10 might investigate that 95% area outside the borders of
11 Canada?

12 MR. FRAWLEY: No, I would have to say
13 there you would be limited to the people you find in
14 Canada. Without making too heavy weather of Smith,
15 Kline and French's Stelazine, which starts with a price of
16 \$1.15 a thousand; they buy that from their parent company.

17 THE CHAIRMAN: That is their import
18 price?

19 MR. FRAWLEY: They buy that. They
20 import that. They take it into their plant, wherever
21 the plant is, in Canada, at a cost of \$1.15. Of course,
22 there are all sorts of considerations as far as that
23 price is concerned. Are there some arrangements between
24 the Philadelphia company and the Montreal company that
25 they have arrived at that price? I am quite conscious
26 of the fact when you get into it, as I respectfully
27 suggest you should, that you will find these things.
28 In any event they start with \$1.15 a thousand. That,
29 I suggest, would have to be your starting point. You
30 couldn't go into Philadelphia and find what it would
cost to make those thousand tablets of Trifluoperazine
or Stelazine. You would have to start at \$1.15. You

in Canada; whether that is a relatively correct figure...

MR. FRAWLEY: It is hard to know what

it is, but it is small.

THE CHAIRMAN: It is small.

MR. FRAWLEY: Very small.

THE CHAIRMAN: Yes, then are imported.

Can you offer any suggestion as to how this Commission might investigate that 80% goes outside the borders of

Canada?

MR. FRAWLEY: No, I would have to say

there you would be limited to the people you find in

Canada. Without making too heavy weather of Smith,

Kline and French's statement, which seems to be a little

MR. FRAWLEY: They buy that. They

import that. They take it into their plant, wherever

the plant is, in Canada, at a cost of \$1.15. Of course,

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or Stelazine. You would have to start at \$1.15. You



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3 can then find out what is it that justifies the spread
4 between the \$1.15 that S.K.F. Canada...

5 THE CHAIRMAN: In Montreal?

6 MR. FRAWLEY: In Montreal. S.K.F.,
7 incidentally, is not S.K.F. Canada. S.K.F. is an
8 American company carrying on the business because it is
9 registered under the Companies Act in Quebec. That is
10 only incidental. They have a starting price of \$1.15.
11 It is sold to the prescription holder at a price equiva-
12 lent to \$95 a thousand. I don't want to make too much
13 of that. Nobody buys a thousand Stelazine tablets, but
14 the price for 50 that they charge, that the retailer
15 charges - he charges it. Of course it is a price fixed
16 by Smith, Kline and French. I guess suggest is the
17 legal word. They will put on that price.

18 My submission to the Commission is you
19 can find out, you can get into this segment, as I asked
20 Mr. Thompson to put on the record for the Restrictive
21 Trade Practices Commission and he firmly, but politely,
22 declined. You can put on record just what goes in,
23 step by step by step until you finally get to the profit.

24 I am not suggesting you are going to
25 find an unwarranted profit - ignore - we don't know,
26 but we do think the public of Canada should know and
27 we think it is an admirable opportunity for the public
28 of Canada to know. If you have to find out, I am quite
29 sure you will find out from the Restrictive Trade Prac-
30 tices. You might only have to cross the street to the
Restrictive Trade Practices and ask them for the benefit
of their investigation. It might not be a difficult

can then find out what is it that justifies the spread

THE CHAIRMAN: In Montreal?

MR. TRAWLEY: In Montreal, S.K.F.

incidentally, is not S.K.F. Canada. S.K.F. is an American company carrying on the business because it is registered under the Companies Act in Quebec. That is only incidentally. They have a starting price of \$11. It is sold to the prescription holder at a price amounting to \$25 a thousand. I don't want to make too much of that. Nobody buys a thousand prescription tablets, but the price for 50 that they charge, that the retailer charges - he charges it. Of course it is a price fixed by Smith, Kline and French. I guess suggest is the legal word. They will put on that price

My submission to the Commission is you can find out, you can get into this argument, as I asked Mr. Thompson to put on the record for the Restrictive Trade Practices Commission and he firmly, but politely, declined. You can put on record just what goes in, step by step by step until you finally get to the point. I am not suggesting you are going to

find an unwarranted profit - ignore - we don't know, but we do think the public of Canada should know and we think it is an admirable opportunity for the public of Canada to know. If you have to find out, I am quite sure you will find out from the Restrictive Trade Practices Commission. You might only have to cross the street to the Restrictive Trade Practices and ask them for the benefit of their investigation. It might not be a difficult



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3 matter.

4 You have to do more than that, in my
5 respectful submission. You have to go into it, give it
6 careful consideration and see whether that spread -
7 there is an awful lot of money spent to get this drug
8 out, to promote it. I am not making an allegation.

9 You might find there is an advantage
10 taken of the Patent Act. You might find why there
11 shouldn't be.

12 THE CHAIRMAN: Leave the patent for a
13 moment because I want to put a question to you in
14 respect of the Patent Act. Will you go ahead and bypass
2 the Patent Act.

15 MR. FRAWLEY: That is just one of the
16 considerations. Then, I would ask you to direct your
17 attention again - I am not suggesting there is anything
18 wrong, why do we not have Stelazine which is, I am sure,
19 made in other parts of the world except by Smith, Kline
20 and French in Philadelphia. Why don't we have that drug
21 in Canada? Why don't the generic drug people bring it
22 in, Trifluoperazine from Italy, Denmark, Britain, France,
23 Japan - why? Well, because they have to go through the
24 procedures of the Food and Drug Directorate, which may
25 be a lengthy process. Of course, they also have the
26 Patent Act. You asked me to leave that aside for a
27 moment. They have to satisfy the Food and Drug Directo-
28 rate with respect to it. They have to have special
29 analyses. They would have to supply a certificate and
30 so on.

 I am only suggesting why is it. So far



You have to do more than that, in my
 respectful submission. You have to go into it, give it
 careful consideration and see whether that answer -
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 out, to promote it. I am not making an allegation.
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 moment because I want to put a question to you in
 respect of the Patent Act. Will you go ahead and bypass
 the Patent Act.
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 made in other parts of the world except by Smith, Kline
 and French in Philadelphia. Why don't we have that drug
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 in, Trifluoperazine from Italy, Denmark, Britain, France,
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 be a lengthy process. Of course, they also have the
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 moment. They have to satisfy the Food and Drug Director-
 ate with respect to it. They have to have special
 analyses. They would have to supply a certificate and
 I am only suggesting why is it, to the



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3 as we know and Dr. Rodman who is here with me, and Mr.
4 Maday of the University Hospital - why there is not more
5 - there is only one drug, one brand of Trifluoperazine
6 which is a very well-known and very effective tranquilizer.
7 There is only one on the market in Canada and that is
8 Smith, Kline and French's Stelazine. I hope I am not
9 putting too much attention on that drug. I am only
10 doing it to illustrate, of course.

11 Now, why is that? Is that because
12 the Food and Drug Directorate make it too difficult for
13 a person to import an Italian drug or a Denmark drug
14 and so on? I only point out these considerations as
15 indicating a question mark; I should say, question
16 marks which I think this Commission is in an ideal
17 position to investigate and you may come up - you can,
18 may find every bit of the spread, every bit of the gross
19 spread is completely justified. As I say I am not
20 making allegations at all, but we do feel we should
21 make this inquiry, study the price list, study the costs
22 as we were able to obtain them, take a look, a very
23 sketchy look at what was done in Washington, examine
24 the list prices in Canada.

25 Looking at the paucity of the generic
26 drugs in Canada, again that is just a question mark.
27 Are there any reasons or insufficient reasons for the
28 lack of widespread use of generic drugs? Are these
29 people who are formulating generic drugs, are they not
30 carrying on their business in the same way; do they not
have the same quality control? These are just questions.
I am putting it to you, what are the reasons that we



as we know and Dr. Robman who is here with me, and Mr. Masey of the University Hospital - why there is not more - there is only one drug, one brand of Typhlopharmazine which is a very well-known and very effective tranquillizer. There is only one on the market in Canada and that is Smith, Kline and French's Stelazine. I hope I am not putting too much attention on that drug. I am only doing it to illustrate, of course.

Now, why is that? Is that because the Food and Drug Directorate make it too difficult for a person to import an Italian drug or a Danish drug and so on? I only point out these considerations as indicating a question mark; I should say, question marks which I think this Commission is in an ideal position to investigate and you say come up - you can say find every bit of the spread, every bit of the gross spread is completely justified. As I say I am not making allegations at all, but we do feel we should make this inquiry, study the whole list, study the costs as we were able to obtain them, take a look, a very exhaustive look at what was done in investigation, examine the list prices in Canada.

I looked at the principle of the generic drugs in Canada, again that is just a question mark. Are there any reasons or insufficient reasons for the lack of widespread use of generic drugs? Are there people who are formulating generic drugs, are they not carrying on their business in the same way; do they not have the same quality controls? These are just questions. I am putting it to you, what are the reasons that we



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4 see so few generic drugs? Particularly I have drawn
5 your attention to the experience the Province of Ontario
6 has had. It is set out at page 105, which I think is
7 rather an interesting situation there. I had to rely
8 on what the Toronto Star said about it. I don't think
9 there can be any question about the veracity of their
10 report because after all it was written down in the
11 Legislative Committee of the Ontario Legislature. Dr.
12 Dymond says we now buy only from houses with non-brand
13 names and he saved \$341,616 in the past 18 months on
14 tranquilizers and barbiturates.

15 I would also like to quote Dr. Martin
16 Cherkasky, Director of the Montefiore Hospital in New
17 York City. I went to the trouble of incorporating it
18 into the brief, what he had to say to the Kefauver
19 Committee as well, which is at page 107 and you will
20 see it there. What he says, and I am reading from page
21 106:

22 "My pharmacist informs me that we save
23 about \$75,000 a year as a direct
24 result of a tightly-controlled formulary
25 system".

26 That, of course, raises a further
27 question which was raised before the Restrictive Trade
28 Practices Commission; why should there not be a more
29 widespread use of what I might loosely call the formulary
30 system in the prescribing and dispensing of drugs? It
just happens that it is a hospital procedure. The physi-
cian, we find as a fact, that the physician dispenses
the brand name, but in the hospital, and I have referred



... your attention to the experience the Province of Ontario has had. It is set out at page 108, which I think is rather an interesting situation there. I had to rely on what the Toronto Star said about it. I don't think there can be any question about the validity of their report because after all it was written down in the Legislative Committee of the Ontario Legislature. Dr. Dwyer says we now buy only from houses with non-organic names and he saved \$25,000 in the past 18 months on tranquillizers and barbiturates.

I would also like to quote Dr. Martin Charkas, Director of the Westmore Hospital in New York City. I want to the people of incorporating it into the field, what he had to say to the Katsenbach Committee as well, which is at page 107 and you will see it there. What he said, and I am quoting from page 107.

"My pharmacist informs me that we save about \$75,000 a year as a direct result of a tightly-controlled formula system."

That, of course, raises a further question which was raised before the Restrictive Practices Commission; why should there not be a more widespread use of what I might loosely call the formula system in the prescribing and dispensing of drugs? It just happens that it is a hospital procedure. The first one, we find as a fact, that the physician dispenses the brand name, but in the hospital, and I have referred



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3 to this in the report; in the hospital the same physician
4 by virtue of agreeing as a member of the staff with the
5 hospital formulary he is quite content that the drug
6 should be dispensed to his patient under its generic
7 name. He has, it is true, the protection of the medical
8 staff, of the pharmaceutical staff, of the pharmacological
9 committee. He has many safeguards, which, of course,
10 are important, which perhaps he feels are not present -
11 that may be another - those are some of the matters
12 which I think warrant the investigation of this Commission.
13 That may be the reason that the dispensing physician
14 dispenses a brand name rather than a generic name. There
15 are only three of them in Canada that hold themselves
16 out as suppliers of drugs under the generic name. It
17 could be not enough is known about these people. Many
18 things, as I say - the whole tenor of this submission is
19 we don't know. We see the spread; we ask you to investi-
20 gate it to see whether or not as a result of your conclu-
21 sions about the sufficiency of that spread then the
22 suggestion that we made as a continuing authority to
23 watch the cost revenue position, see where it gets out
24 of line - whether that would be a salutary thing.

25 Of course, there is another thing that
26 should be drawn to the attention of the Commission. Now
27 I am in the way of briefly summarizing this brief, I
28 think I agree with the Canadian Pharmaceutical Association
29 that it is not difficult to conclude that the high cost
30 of prescription drugs at the retail counter subsidizes
the large purchases which many others, the people I
represent here today, buy at prices which they do.



to this in the report; in the hospital the same physician
by virtue of agreeing as a member of the staff with the
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should be dispensed to his patient under its generic
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we don't know. We see the spread; we ask you to investi-
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watch the cost revenue position, see where it gets out
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of prescription drugs at the retail counter subsidizes
the large purchases which many others, the people I
represent here today, pay at prices which they do.



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3 THE CHAIRMAN: Including the University
4 Hospital?

5 MR. FRAWLEY: And the Department of
6 Health, Dr. Ross' own Department. Dr. Ross is not
7 going to be frightened away, he is still going to
8 continue. He is using public funds and he will insist
9 upon very, very low prices for these quantity purchases.
10 As I say, I suggested in the brief if it should be, and
11 I don't think it is practical, to have the manufacturers
12 say "Oh well, if the finger is pointed we will have to
13 up the prices to the large buyers". Well, the large
14 buyers will say, "Well, perhaps you will, perhaps you
15 won't. We might find other places to go and buy them.
16 We might go to Italy ourselves, or Denmark". I simply
17 say it is something - gross subsidization should not be
18 discharging itself in other prices. I have suggested
19 it is in other places. It existed in the freight rate
20 structure. I convinced myself a long time ago of that.
21 Now I find it is here. I suggest we find it in many
22 places. At the moment we are concerned with the high
23 cost of drugs. If you find there is a gross subsidiza-
24 tion and if you find there is any possibility of relief
25 from it again that is an area of investigation.

26 THE CHAIRMAN: When I mentioned the
27 Patent Act, what do you suggest? Do you make any sugges-
28 tion as to what might be done that isn't now in respect
29 of the Act which provides that so far as a patent that
30 covers the food or drug, anyone may apply for a licence
to manufacture it in Canada?

MR. FRAWLEY: Yes.



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THE CHAIRMAN: Including the University

Hospital?

MR. TRAWLEY: And the Department of

Health, Dr. Ross' own Department. Dr. Ross is not

going to be frightened away, he is still going to

continue. He is using public funds and he will insist

upon very, very low prices for these quantity purchases.

As I say, I suggested in the letter if it should be, and

I don't think it is practical, to have the manufacturer

pay the prices to the large buyers. Well, the large

buyers will say, "Well, perhaps you will, perhaps you

won't. We might find other places to go and buy there

we might go to Italy ourselves, or Denmark". I simply

say it is something - gross subsidization should not be

discouraging itself in other prices. I have suggested

it is in other places. It existed in the right way

structure. I convinced myself a long time ago that

now I find it is here. I suggest we find it in many

places. At the moment we are concerned with the high

cost of drugs. If you find there is a gross subsidiza-

tion and if you find there is any possibility of relief

from it again that is an area of investigation.

THE CHAIRMAN: When I mentioned the

Patent Act, what do you suggest? Do you make any sugges-

tion as to what might be done that isn't now in respect

of the Act which provides that as far as a patent that

covers the food or drug, anyone may apply for a licence

to manufacture it in Canada?



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4 THE CHAIRMAN: Without a limitation of
time.

5 MR. FRAWLEY: As you know that is the
6 only place where you find that compulsory purchase, with
7 respect to drugs.

8 THE CHAIRMAN: The Act that has been
9 introduced in Congress is to get it to a three-year
10 period.

11 MR. FRAWLEY: Well, I only can say I
12 hope it is more valuable to them than it is to Canada.
13 It has been of no particular importance at all. There
14 has been no use, no substantial use. That was the
consensus at the Restrictive Trade Practices Commission.

15 THE CHAIRMAN: That is an interesting
16 question. I wondered if you had any observation to make
17 upon it because if there is such good profit margins
18 and you get a licence to manufacture this drug, which
19 you suggest jumps in price 10 to 100 to 1,000%, why
20 doesn't someone go into the business in Canada instead
of leaving such a large percent to be imported, 95%?

21 MR. FRAWLEY: That is where the situation
22 gets a little foggy, because there is so little manufac-
23 turing in Canada anyway. Supposing that you and I
24 thought we should manufacture Trifluoperazine and took
25 out a compulsory patent from Smith, Kline and French.
26 That patent is in Philadelphia, as I understand it.
27 Where would we get the patent and would we manufacture
28 it in Canada? Smith, Kline and French aren't doing that.
29 It is rather difficult to just put your finger on what
would follow from an application to the Commissioner for
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MR. FRANKLY: That is where the situation turns in Canada anyway. Supposing that you and I thought we should manufacture Trilliopeazine and took out a compulsory patent from Smith, Kline and French. That patent is in Philadelphia, as I understand it. Where would we get the patent and would we manufacture it in Canada? Smith, Kline and French aren't doing that. It is rather difficult to just put your finger on what would follow from an application to the Commission for



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3 a compulsory patent to manufacture Trifluoperazine..
4 The Commissioner gave evidence and he wonders himself.
5 I think he would be very anxious and willing to give the
6 patent.

TO/dpw 7 But what would happen are the facilities
8 for manufacturing that drug here in Canada-- well,
9 Smith, Kline and French apparently does not think so.
10 They apparently import the finished product.. So, again,
11 we are left with a question mark.

12 THE CHAIRMAN: Mr. Frawley, are you in
13 a position to give us a figure on the cost in a twelve-
14 month period of prescription drugs in Canada?

15 MR. FRAWLEY: Oh, no, and I do not know
16 that we have that anywhere in the--

17 THE CHAIRMAN: Any figure that has been
18 suggested to us is \$200,000,000.

19 MR. FRAWLEY: There has been a figure
20 suggested of \$200,000,000?

21 THE CHAIRMAN: Yes.

22 MR. FRAWLEY: I do not know.. None of
23 my people have had available to them enough information.
24 That would have to be done, sir, by someone who would
25 have access to full statistics.

26 THE CHAIRMAN: Perhaps we may come to
27 Alberta.. Are you in a position to say what the prescrip-
28 tion cost is per capita in Alberta -- prescription drugs?

29 MR. FRAWLEY: There were some figures
30 taken of prescription drugs. No, I think not -- not of
prescription drugs. There were some figures presented
showing the cost of -- well, in any event, there may



a complete y parent to manifest in the future
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But what would be the result of the
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They apparently insist that the
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3 have been a figure but not the prescription of drugs.

4 THE CHAIRMAN: Of roughly \$10 per
5 capita?

6 MR. FRAWLEY: Per annum?

7 THE CHAIRMAN: Per annum.

8 MR. FRAWLEY: I did not have that
9 figure.

10 HON. DR. ROSS: Mr. Cameron, who is
11 Secretary of our Alberta Pharmaceutical Association may
12 answer that.

13 MR. CAMERON: Mr. Chairman, using the
14 three sources quoted in our brief, we have committed
15 the per capita per annum expenditure on prescription
16 drugs through drugstores only as \$8.67.

17 THE CHAIRMAN: Yes, and then with some
18 other sources coming to a rough figure of \$10. And,
19 then, on a population in Canada of between eighteen and
20 nineteen million people, coming up that goes to \$200,000,000

21 MR. FRAWLEY: I would like to make this
22 observation. There are prescription drugs and prescrip-
23 tion drugs, and you will observe that I have limited
24 myself to antibiotics, corticosteroids and tranquilizers.
25 Those are the expensive drugs. If there is a burden on
26 the prescription patients, that is where the burden is
27 on the prescriptions. I have limited myself in the
28 preparation of this exhibit to those. Now, there are
29 lots of prescriptions, lots of drugs sold on a prescrip-
30 tion basis.

THE CHAIRMAN: You see, we wonder if
you are able to give us any assistance on the impact of

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3 these drugs you mention upon the individual?

4 MR. FRAWLEY: No, because you see that
5 is precisely why. Nobody has ever excised out those
6 three groups. As Mr. Isaacson, the Toronto druggist
7 who gave evidence to the Restrictive Trade Practices
8 Commission said, these high-priced drugs-- no one has
9 taken out that group of drugs and endeavoured to put a
10 dollar figure on them. When you say prescription drugs,
11 you have a lot of inexpensive drugs. After all, there
12 are inexpensive prescription drugs. Parke-Davis' Colchi-
13 cene for \$1 for 50 tablets, Merck's Decadron sells for
14 \$29.80 for 100 tablets.

15 There are, as I say, drugs and drugs.
16 Frankly, not for the purpose of making a case, because
17 we thought that was where the burden was, we have
18 limited ourselves to the expensive drugs, the newer
19 prescriptions.

20 THE CHAIRMAN: Have you any views to
21 express upon this aspect of drugs, of the retailing of
22 drugs to the individual, whether by physicians, either
23 operating a pharmacy or a group operating a pharmacy as
24 to subsidization of the medical practice to the sale of
25 drugs?

26 MR. FRAWLEY: No, my research did not
27 take me into that, but I think it is a field which the
28 Commission might investigate.

29 THE CHAIRMAN: We heard much of that
30 in Manitoba.

MR. FRAWLEY: I read in the Canadian
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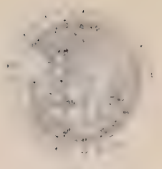
4 THE CHAIRMAN: In a limited sense. That
5 is what was being suggested.

6 MR. FRAWLEY: In Alberta, that is not
7 being done. As the chart indicates, there are two sides
8 to it: what the wholesaler and retailer takes and what
9 the manufacturer takes.

10 Looking at what the wholesaler and
11 retailer takes, I think there is a very important difference
12 between pharmacists. You have pharmacists who
13 fill half-a-dozen prescriptions in a day, and you have
14 the pharmacist situated in one of these fine office
buildings who may fill 100 prescriptions a day.

15 In my respectful submission, those are
16 two quite different animals, and I think that the
17 Commission, if it embarks upon the study, which I respectfully
18 submit they should, should just look into that and
19 find out whether or not that is profitable. And I say
20 that because the Canadian Pharmaceutical Association in
21 its submission to the Restrictive Trade Practices Commission
22 said that consideration was being given -- they
23 did say that consideration was being given to the insufficiency
24 of the 40% discount which is presently what the
25 pharmacist operates on. It was felt that that 40%
26 should perhaps go to 50%. The witness who gave the
evidence said they would hope to do that without
increasing the list price, which was rather comforting.

27 When you examine the sufficiency of
28 the 40%, you have to apply that to the gentleman who
29 has the fine pharmacy in the professional building and
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3 the pharmacist who has a country drugstore, we will say,
4 and fills a few prescriptions a week, and that is an
5 obvious point which I am sure will receive the considera-
6 tion of the Commission. I think nothing should be left
7 unexplored. I think you should determine whether the
8 40% -- it is not only 40%, because there is also a
9 prescription fee which is added to the 40%. I think I
10 will say this for the pharmacist, that the pharmacist
11 who gave evidence and most completely in Toronto before
12 the Restrictive Trade Practices Commission did say that
13 on the high-priced drugs he would not add the prescrip-
14 tion fee, which was certainly commendable, although not
15 too profitable as far as he was concerned.

15 THE CHAIRMAN: Is there any legislation
16 in Alberta dealing with the operation of a pharmacy by
17 a corporation?

18 MR. FRAWLEY: No, there are no restric-
19 tions. I am instructed that a corporation could open a
20 drugstore, but he would have to have employees who were
21 registered pharmacists.

22 THE CHAIRMAN: But the ownership may
23 vest in any one?

24 MR. FRAWLEY: Yes, I think that is true.
25 As a matter of fact, I noticed that some of the drug-
26 stores are called so-and-so limited. Dispensaries
27 Limited is one who operate several drugstores.

28 THE CHAIRMAN: But in some provinces we
29 have been told that either the shareholding or the
30 directors must be in the hands of licensed pharmacists?

MR. FRAWLEY: Yes. Well, I do not think



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3 we have any such law in Alberta.

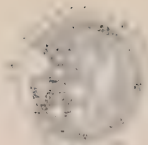
4 No, I am assured that in Alberta there
5 is no such restriction.

6 COMMISSIONER BALTZAN: I have just one
7 question for you, Mr. Frawley. We are talking continually
8 about the value of these drugs. There is always a
9 question about the lower price and the lack of potency.
10 Who controls that? I do remember an instance long ago
11 when a manufacturer came out and sold a known drug at
12 half the price, supposedly containing the same number of
13 grains of the ingredient. Then, after three or four
14 months it was determined that it did not have its full
15 potency, and he could afford to sell it cheaper, at
16 half the price.

16 MR. FRAWLEY: I think it is quite clear
17 that the Food and Drug Directorate -- that is one of
18 their principal purposes, and I am quite sure they do
19 effective work in that regard in examining.

19 Dr. Morrell, the Director, said they
20 do it on the basis of spot checks. As some gentleman
21 said, he thought if his staff were multiplied threefold
22 he would not mind at all; he would be very pleased --
23 not because there were a lot of non-potent drugs, but
24 just that he felt he could do with a larger staff.

25 COMMISSIONER McCUTCHEON: Mr. Frawley,
26 just one point. Why is the province so helpless in this
27 field? You have indicated to the Chairman that you had
28 not gone so far as to suggest that the Federal Government
29 might introduce price fixing in this field? Why cannot
30 the province do that? Why cannot it restrict advertising?



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4 does in other fields?

5 MR. FRAWLEY: Why can't the province
6 not set up a price fixing routine for drugs?

7 COMMISSIONER McCUTCHEON: Right.

8 MR. FRAWLEY: Well, I think ---

9 HON. DR. ROSS: As a government, we
10 have never been in favour of price fixing.

11 COMMISSIONER McCUTCHEON: Who do you
12 want to do it for you?

13 HON. DR. ROSS: We feel there are other
14 ways of meeting the problems that at times arise.

15 MR. FRAWLEY: That is why I was trying
16 to take pains to say I was not advocating this should
17 suddenly become a matter of public utility control. I
18 think there is a difference between suggesting that we
19 police the cost revenue. It is a different thing than
20 embarking holus bolus on a public utility of drugs such
21 as we have for milk.

22 COMMISSIONER McCUTCHEON: What does
23 policing the cost revenue position mean, Mr. Frawley?
24 Let us suppose there is an agency which has jurisdiction
25 to obtain this information, and there may be some diffi-
26 culty in establishing the authority of a full agency to
27 do that, outside of the Dominion Bureau of Statistics.
28 What use is it to obtain that information unless you can
29 give it publicity? It is suggested in your brief, I
30 think, that one of the effects should be that this infor-
mation be publicized and that would act as a moral assuage-
ment on the offender?



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4 MR. FRAWLEY: I am old enough to suggest
5 that the mere fact there was someone there empowered to
6 demand all the information necessary to determine the
7 precise status of the cost revenue position at any time,
8 that that alone would have an effect. You see, I am
9 encouraged by the fact that the biggest manufacturer in
10 Canada, Cyanamid, must have come to the conclusion, and
11 I think it is a warranted conclusion, that there is a
12 burden there in this excessive cost of bringing the drug
13 to Toronto and to the pharmacist. He suggests some go-
between to keep that information before the interested
parties.

14 Well, now, a continuing body, always
15 aware of the relationship between cost and price -- I
16 think we would have to let some of these things find
17 their own level, and without promising too much for it
18 at the beginning, that it would be in my respectful
19 submission a step forward. I say this because at the
20 moment, you see, there is not any control at all. The
21 Food and Drug Directorate tell me they are not at all
concerned whether the cost of drugs is high or not.

22 COMMISSIONER McCUTCHEON: But the
23 province could take an interest in that field, constitu-
24 tionally, if it wanted to. Never mind whether it is
their philosophy to do it, it could?

25 MR. FRAWLEY: It is inter-provincial
26 trade. I would not want to be too sure. We do not
27 manufacture drugs in this country. If we endeavoured
28 to fix the price on, say, Merck's Decadron, they would
29 say it is manufactured in Rahway, New Jersey, and it is
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4 sent out to Edmonton; what right have you to fix the
5 price of this?

6 THE CHAIRMAN: What right have you to
7 fix the price of Catto's whisky?

8 It is funny, but ---

9 MR. FRAWLEY: Because it has been
10 decided, certainly by the Supreme Court of Canada and
11 by the Privy Council, that the prohibition against
12 liquor sale and the channelling of it into whatever way
13 we want is wholly a matter within the sphere of the
14 province.

15 THE CHAIRMAN: Do you think there would
16 be a different judicial view of drugs as distinct from,
17 say ---

18 COMMISSIONER McCUTCHEON: Margarine.

19 THE CHAIRMAN: We have the Province of
20 Quebec and the Province of New Brunswick restricting the
21 sale of margarine.

22 MR. FRAWLEY: Perhaps to some extent in
23 other provinces, too. I would not say that we could not
24 fix the price of drugs. I just say it might be question-
25 able whether we could establish the price of drugs. But
26 I have got to say, because I am here as counsel for the
27 Government of Alberta, that that is not the policy of
28 the Province of Alberta to go into price fixing.

29 THE CHAIRMAN: We must talk in terms
30 of ten provinces. This Commission, while it has respect
for the views of the Province of Alberta, is necessarily
Canada-wide, and therefore we ask for the views and ask
for them very seriously, but in terms of what it might

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3 be on an overall Canadian policy.

4 MR. FRAWLEY: I would like to put to
5 the Commission that it falls into the pattern that is
6 already existing. We have a form of control of drugs
7 at the moment through a Food and Drug Directorate and
8 through the Patent Act, at least if not otherwise, and
9 it is essentially inter-provincial trade and it is inter-
10 national trade, as a matter of fact, and it does seem to
11 me that it lends itself to the limited degree of -- I
12 would not even say control -- I would not even use the
13 word "control". It lends itself to the limited degree
14 of continued information about what goes into the spread
15 between cost and price.

16 THE CHAIRMAN: The purpose of discussing
17 it is to be of assistance, and you are being of assis-
18 tance to us, Mr. Frawley. It is not a matter of trying
19 to put you on the spot on this.

20 MR. FRAWLEY: Thank you very much, but
21 the greatest assistance I could be to the Commission is
22 to excite you to some extent with regard to these spreads
23 and a further investigation through your own research
24 staff would be warranted.

25 COMMISSIONER McCUTCHEON: Your final
26 decision is, Mr. Frawley, that if there were some federal
27 agency, and I have not thought through where it would
28 derive its jurisdiction to do such a thing, but if there
29 were some federal agency that could continuously obtain
30 reports from manufacturers, wholesalers, and so on, and
determine what spreads were and what costs were, and that
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4 mere fact that somebody was doing that might induce or
5 result in some restraint on some of the activities which
6 you question.

7 MR. FRAWLEY: Yes, and when I used the
8 word "activity", there are activities in the sense of
9 the competitive race these people are in. Now, with
10 that use of the word activity, I agree with what you
11 say, Mr. McCutcheon.

12 COMMISSIONER McCUTCHEON: That is your
13 case?

14 MR. FRAWLEY: Yes.

15 COMMISSIONER FIRESTONE: Mr. Chairman,
16 I would like to compliment the Minister and Mr. Frawley
17 on the comprehensive drug chapter included in their
18 submission. This is a clear statement of the problems
19 we are facing in the field of high drug prices in Canada
20 and what can be done about it. It is the most complete
21 statement we have received. We are very grateful for
22 it, and it will be helpful to the Commissioners and to
23 the research staff to look into the question very care-
24 fully.

25 Rather than go into detail, I am going
26 to pick out just one drug and try to follow it through
27 to see what some of the problems are. You have given
28 us a lot of information and this has to be examined and
29 studied carefully. If I may be forgiven for picking up
30 just one drug, it is mainly for the purpose of illustra-
tion of what the problem is.

I am referring to page 86, paragraph
301.



were fact that somebody was doing that might induce or result in some restriction on some of the activities which you question.

MR. TRAWLEY: Yes, and when I used the word "activity", there are activities in the sense of the competitive race these people are in. Now, with that use of the word activity, I agree with what you

COMMISSIONER MCCONNELL: That is your

answer?

MR. TRAWLEY: Yes.

I would like to compliment the Minister and Mr. Bradley on the comprehensive group of questions asked in their submission. This is a clear statement of the problem we are facing in the field of high drug prices in Canada and what can be done about it. It is the most complete statement we have received. We are very grateful for it, and it will be helpful to the Commissioner and to the research staff to look into the question very carefully.

Rather than go into detail, I am going to pick out just one drug and try to follow it through to see what some of the problems are. You have given us a lot of information and this has to be examined and studied carefully. If I may be forgiven for picking up just one drug, it is mainly for the purpose of illustrating



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MR. FRAWLEY: Yes, I have it.

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COMMISSIONER FIRESTONE: You

speak of Tetracycline, which is, I understand, an anti-biotic. And you say that the prime cost for the basic drug is \$3.50. You further say the list price for Tetrex which is Bristol's brand name of tetracycline is \$47.84 for 100 tablets -- a difference of over 1,300%.

You further say at paragraph 343 on page 101 that the University Hospital buys the same drug at \$12.50 per 100 tablets in large quantities. Now, between the cost of \$3.50 and the price the hospital pays of \$12.50 there is a difference of over 300%. Just for the purpose of illustration, has your Government or any officials or anyone else in your administration looked into the question as to why there exists such wide variations in one case over 300% and in the other case over 1,300%?

MR. FRAWLEY: When you say have we looked into the spread, have we questioned the manufacturers as to why there should be that spread, I think I can begin by saying I am quite certain that the University Hospital until it saw the Green Book had no information at all that Tetracycline was being imported at a theoretical prime cost for the ingredient of \$3.50 per 100 tablets. Then, as to what the University Hospital might have done to demand from its vendors better prices, I think the University Hospital themselves would do it. In this instance, and that \$12.50, by the way, is a tender price, they did all they could do and they called for their requirements of Tetracycline by tender and a firm in Montreal filled the order for \$12.50. I can say

MR. FRANKLY: Yes, I have it.

asked of Tetracycline, which is, I understand, an anti-biotic. And you say that the prime cost for the basic drug is \$3.50. You further say the list price for Tetrex which is Bristol's brand name of tetracycline is \$47.84 for 100 tablets -- a difference of over 1,300%. You further say an average hospital pays the same drug at \$12.50 per 100 tablets in large quantities. Now, between the cost of \$3.50 and the price the hospital pays of \$12.50 there is a difference of over 300%. Just for the purpose of illustration, has your Government or any officials or anyone else in your Administration looked into the question as to why there exists such wide variations in one case over 300% and in the other

MR. FRANKLY: When you say have we

looked into the question, have we questioned the market-
there as to why there is such a big difference, I think I can begin by saying I am quite certain that the University Hospital until it saw the Green Book had no information at all that Tetracycline was being imported at a theoretical prime cost for the Government of \$3.50 per 100 tablets. Then, as to what the University Hospital might have done to demand from its vendors better prices, I think the University Hospital themselves would do it. For their requirements of Tetracycline by tender and a firm in Montreal filled the order for \$12.50. I can say



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3 little more than that.

4 Perhaps I could put it in a question
5 form; would we not be in somewhat the same position
6 when I asked Mr. Thompson of the Lederle Company what
7 goes into that difference and he said "I won't tell you,
8 I won't put it on the public record". Probably they
9 would tell the University Hospital in more polite
10 language because they are customers but perhaps they
11 would not tell them.

12 COMMISSIONER FIRESTONE: I presume the
13 reason why somebody would be interested in both costs
14 and retail price is to get the best possible deal as a
15 buyer?

16 MR. FRAWLEY: Yes.

17 COMMISSIONER FIRESTONE: And I take it
18 that the buyer wants to protect himself the best way he
19 can. I take it you feel that the tender system is provi-
20 ding that protection but would you know whether the
21 University Hospital has examined, for instance, prices
22 of the corresponding drugs sold in other countries and
23 the possibility of importing these drugs. Taking this
24 as an example but there may be many others, importing
25 them at lower costs from abroad.

26 MR. FRAWLEY: I will ask Mr. Maday who
27 is the Assistant Director of the University Hospital and
28 the senior pharmacist there to answer the question. I
29 would ask you to look at page 3 of the exhibit and you
30 will find there that Mr. Maday paid this \$12.50 and at
the same time the list price was \$32, the pharmacist
was paying \$19.20, the wholesaler, \$17.28 and I suppose

little more than that.

form; would we not be in somewhat the same position when I asked Mr. Thompson of the Bedale Company what goes into that difference and he said "I won't tell you, I won't put it on the public record". Probably they would tell the University Hospital in more polite language because they are customers but perhaps they would not tell them.

COMMISSIONER: I presume the

reason why somebody would be interested in your costs and retail price is to get the best possible deal as a

COMMISSIONER: And I take it

that the buyer wants to protect himself the best way he can. I take it you feel that the tender system is providing that protection but would you know whether the University Hospital has examined, for instance, prices of the corresponding drugs sold in other countries and the possibility of importing these drugs. Taking this as an example but there may be many others, importing them at lower costs from abroad.

MR. TRUVELLY: I will ask Mr. Mabey who

is the Assistant Director of the University Hospital and the senior pharmacist there to answer the question. I would ask you to look at page 3 of the exhibit and you will find there that Mr. Mabey paid this \$12.50 and at the same time the list price was \$22, the pharmacist was paying \$18.50, the wholesaler, \$17.28 and I suppose



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3 Mr. Maday thought he was doing pretty well at \$12.50.

4 COMMISSIONER FIRESTONE: Well, of
5 course, "doing pretty well" is just a relative term but
6 assuming he could get the drug at a lower cost abroad
7 he could still do better.

8 MR. FRAWLEY: Mr. Maday, you have
9 heard what Dr. Firestone has said, would you be good
10 enough to offer any observations.

11 MR. MADAY: Yes, we possibly could do
12 better but I do not know what the situation - I do not
13 know what the market is like over there. This would
14 necessitate that I would go over and view it or refer
15 to someone who has viewed it and this would bring in
quite a few costs.

16 THE CHAIRMAN: You mean the quality of
17 drugs abroad?

18 MR. MADAY: No, the supply.

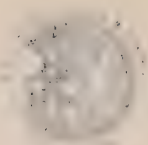
19 COMMISSIONER FIRESTONE: And the prices.

20 MR. MADAY: That is right.

21 COMMISSIONER FIRESTONE: Have you been
22 in consultation with other pharmacists in other provinces
23 who might have gone abroad and could have done exactly
24 what I have suggested the University of Alberta Hospital
could do?

25 MR. MADAY: Yes, I have just discussed
26 with other pharmacists but, unfortunately, none of them
27 have had the opportunity of making a complete study of
the picture.

28 COMMISSIONER FIRESTONE: But you do not
29 know whether some have gone or not?
30



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MR. MADAY: I am pretty sure there are none have gone over for that specific purpose.

COMMISSIONER FIRESTONE: This specific drug or any drug?

MR. MADAY: Any drug.

COMMISSIONER FIRESTONE: Thank you. We will be asking the same questions over and over during our trip and at the end we shall be able to decide whether any attempts have been made to do as I have suggested. We have been told of a number of countries where prices of drugs are lower, where individuals are importing drugs at considerably lower prices in small lots. Now if individuals can do this in small lots would not the hospital be in a stronger competitive position? If that is true it might take an initial expense to send the pharmacist, he would have to check and perhaps go to Ottawa, etc. However, the question arises and this I would like to direct to the Minister, if I may: if there are some problems in setting up a system of control and this was not brought out in the discussion so far, whether there are not certain things that drug buyers can do, whether acting together or separately, in institutions, to protect themselves? One way to protect themselves is to encourage competition and one way to do that is to not only encourage competition in Canada but competition between the foreign manufacturers and resident importers because that is what they are; 90% or 95% are nothing but resident importers. Presumably if you succeed in getting your government and other provincial governments to succeed in



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drug or any drug.

COMMISSIONER: Thank you.

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3 bringing in fairly large quantities this will have a
4 salutary effect on the so-called resident importers.
5 Perhaps through the process of competition it will
6 bring prices to a more reasonable level and others can
7 rely on provincial governments to make our competitive
8 position more effective.

9 MR. MADAY: Dr. Firestone, I think that
10 even this inquiry here will have an effect. As we
11 have seen during the past year or two the drug prices
12 have come down considerably because of public concern
13 at the level at which they worked. I think that your
14 investigation across Canada when you are being impressed
15 with this as a possible problem in the cost of develop-
16 ment of health programs for our people will result in a
17 consideration by the manufacturers of our drugs in rela-
18 tion to what they will eventually cost the consumer.

19 In answer to your question "Can provin-
20 cial governments become effective agents in developing
21 some increased competitive spirit among our resident
22 pharmaceutical manufacturing houses by looking beyond
23 the borders of Canada for the necessary supplies of
24 their drugs?", I would say that I think we could. We
25 do this in many areas, go beyond our borders in looking
26 for supplies for other types of things, to Japan and
27 some of the other countries that are coming into our
28 markets. Just what might develop if this became a wide-
29 spread type of program on the part of governments or
30 perhaps new major wholesale drug houses, is something
that I think only the people in the House of Commons
would be able to tell us.



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spread type of program on the part of governments or
perhaps new major wholesale drug houses, is something
that I think only the people in the House of Commons
would be able to tell us.



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4 I think the question is, how do we
5 relate the total economy of Canada to a particular area
6 of our economy in the individual provinces? Do we sell
7 out our own Canadian interests for some savings in a
8 particular field that we find is not there a few years
9 down the road? We have to have something within our own
10 borders. These are problems you have to think about
11 when you think about going beyond our own Canadian
12 borders for the importation of drugs. Certainly I
13 would think this is something that you would have to
14 give consideration to if our own Canadian people in
15 this field were not going to be competitive.

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17 COMMISSIONER FIRESTONE: I think that
18 we have pretty well agreed earlier that something like
19 90% or 95% of our drugs are imported so it is competition
20 now between importers of one kind or another. The neces-
21 sity is to protect the Canadian consumer and get the
22 lowest possible price for a high quality drug.

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24 Now, if you could bring this question
25 to a specific conclusion, if the University Hospital
26 would go to the Minister of Health and say "We would
27 like to spend \$5,000 to send our senior pharmacists on
28 a trip to Europe and bring back a number of proposals" -
29 I don't want you to answer the question "yes" or "no"
30 but I am putting this as a hypothetical question, would
you consider that some practical approach would do no
harm in trying to see what could be done? Perhaps \$5,000
would be completely wasted but until you have put this
matter to a test you really do not know whether this
would be an effective means or not. I regard my



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 relate the total economy of Canada to a particular area
 of our economy in the individual provinces? Do we sell
 out our own Canadian interests for some savings in a
 particular field that we find is not there a few years
 down the road? We have to have something which can cut
 borders. These are problems you have to think about
 when you think about going beyond our own borders
 borders for the imposition of duties. Certainly I
 would think this is something that you would have to
 give consideration to if our own Canadian people in
 this field were not going to be competitive.

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 50% or 55% of our drugs are imported so it is competition
 now between imports of one kind or another. The neces-
 sity is to protect the Canadian consumer and get the
 lowest possible price for a high quality drug.
 Now, if you could bring this question
 to a specific conclusion, if the Ministry Hospital
 would go to the Minister of Health and say "We would
 like to spend \$5,000 to send our senior pharmacists on
 a trip to Europe and bring back a number of proposals" -
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 you consider that some practical approach would be to
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 would be completely wasted but until you have put this
 matter to a test you really do not know whether this
 would be an effective means or not. I regard it



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3 question as hypothetical, not one that has a practical
4 application.

5 MR. MADAY: There are a number of people
6 from my University Hospital sitting behind me and along
7 the side here and for their benefit I would say I have
8 not as yet had a trip to the Orient and perhaps the
9 Minister might be a more legitimate man to go but I
10 would think that if the cost of the operation on our
11 total hospitalization program in Alberta might be affected
12 from such an expenditure I think perhaps even our Direc-
13 tor of Hospitals might give consideration to this.
14 However, not having discussed this with anybody at the
15 present time I would only say it would be taken under
16 advisement for consideration in the possible future for
17 decision at a later date.

18 MR. HOMAN: Mr. Chairman, in answer to
19 Dr. Firestone's question; in the last few years only in
20 one case did we receive a drug direct from a foreign
21 country. This is at the present time a foreign country
22 which our Canadian Government is pleased to be extending
23 its channels of international trade to. We knew only
24 of this source of supply. We negotiated for the purchase
25 of this drug to be supplied to our Department of Public
26 Health, Edmonton, Alberta, Canada, and we were situated
27 in the United States of America and we paid for it in
28 United States dollars; we could not even pay for it in
29 Canadian dollars. Furthermore, we asked that it be sent
30 air express and when we found it was on the high seas by
boat, we ordered a second order. By the time we cleared
the Food and Drug Directorate and the import duties and



question as hypothetical, not one that has a practical

MR. MADAY: There are a number of people from my University Hospital sitting behind me and along the side here and for their benefit I would say I have not as yet had a trip to the Orient and perhaps the Minister might be a more legitimate man to go but I would think that if the cost of the operation or the total hospitalization program in Alberta might be offset from such an expenditure I think perhaps even an increase of hospitals might give consideration to this. However, not having discussed this with anybody at the present time I would only say it would be a long matter for consideration in the possible future for decision of a later date.

MR. HOWARD: Mr. Chairman, in regard to Dr. Westcott's question, in the last few years only in one case did we receive a drug direct from a foreign country. This is at the present time a license of import which our Canadian Government is pressed to be extending the channels of international trade not a new one on this source of supply. We negotiated for the purchase of this drug to be supplied to our Department of Public Health, Edmonton, Alberta, Canada, and we were situated in the United States of America and we said for it in United States dollars; we could not even pay for it in Canadian dollars. Furthermore, we said that it be sent air express and when we found it was on the high seas by post, we ordered a second order. By the time we cleared the Food and Drug Directorate and the import duties and



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4 customs we would gladly have paid somebody else down the
5 street a little extra to have it sent from Calgary,
6 Winnipeg or Montreal or from a vendor down the street.

7 That is an isolated case and perhaps
8 in such a rarity you find this. However, if there was
9 a big business properly detailed there, perhaps there
10 might be advantages to it.

11 MR. FRAWLEY: I am sure you can do much
12 better if you went over to see about it.

13 COMMISSIONER FIRESTONE: I can under-
14 stand individual cases will run into all kinds of diffi-
15 culties. This would have to be done on a large-scale
16 basis.

17 May I go now to one other question?
18 You deal with, in paragraph 342, purchase by tender and
19 as I understand it some hospitals call for tender and
20 some do not. Am I right in that understanding?

21 MR. FRAWLEY: I think it might help to
22 answer your question if you went to Appendix B and there
23 on page 2, the first section of Appendix B deals with
24 the University of Alberta Hospital's experience with
25 tenders and with the Department of Public Health. Appro-
26 pos of what you are asking, would you look at page 2 and
27 we quote there a letter of Dr. J.B. Wallace, Executive
28 Director, University of Alberta Hospital:

29 "In a hospital as large as this one,
30 the practice of tendering for drugs
has proven to be very satisfactory.

This results primarily from the quan-
tities that can be ordered at one time.



customers we would gladly have paid somebody else down the street a little extra to have it sent from Calgary, Winnipeg or Montreal or from a vendor down the street. That is an isolated case and perhaps in such a rarity you find this. However, if there was a big business properly detailed there, perhaps there might be advantages to it.

MR. TROWER: I am sure you can do much better if you went over to see about it. COMMISSIONER: I can understand individual cases will run into all kinds of difficulties. This would have to be done on a large-scale

may I go now to one other question? You deal with, in paragraph 34, purchases by tender and as I understand it some hospitals call for tender and some do not. Am I right in that understanding?

MR. TROWER: I think it might help to answer your question if you went to Appendix I and there on page 1, the first section of Appendix B deals with the University of Alberta Hospital's experience with tenders and with the Department of Public Health. I suppose of what you are asking, would you look at page 2 and we quote there a letter of Dr. J. J. Wallace, Executive Director, University of Alberta Hospital:

In a respect as large as this one, the practice of tendering for drugs has proved to be very satisfactory. This results primarily from the quantities that can be ordered at one time.



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4 Similar procedures could be used to
5 advantage by other large, metropolitan,
6 general hospitals, but it is doubtful
7 whether individual small hospitals
8 could carry out such procedures.

9 In the past, in several areas of the
10 province, groups of hospitals have
11 endeavoured to set up central purchasing
12 of drugs, but previous restrictions
13 with regard to sales tax have made it
14 difficult to complete such organization.
15 At the present time some consideration
16 to this matter is being given by the
17 Associated Hospitals of Alberta".

18 Does that help to answer your question?

19 COMMISSIONER FIRESTONE: Yes, but I
20 was going to follow it a little further and inquire as
21 to what hospitals in the Province of Alberta are using
22 the tender system?

23 MR. FRAWLEY: Surely with all these
24 people here we can get an answer to that.

25 HON. DR. ROSS: I would imagine most
26 of the large metropolitan hospitals do - we have four
27 in the city ---

28 MR. FRAWLEY: We might make an inquiry
29 for you and supply that in an orderly fashion. We will
30 find out what we can about which hospitals are now using
the tender system.

COMMISSIONER FIRESTONE: Assuming we
get the information and I am more concerned about the



Trawlley

Similar procedures could be used to advantage by other large, metropolitan, general hospitals, but it is doubtful whether individual small hospitals

in the past, in several cases of the province, groups of hospitals have endeavored to set up central purchasing of drugs, but previous restrictions with regard to sales tax have made it difficult to complete such organization. At the present time some consideration to this matter is being given by the associated hospitals of Alberta. Does that help to answer your question?

COMMISSIONER FIRSTONE: Yes, but I

was going to follow in a little further and inquire as to what hospitals in the province of Alberta are using the tender system?

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MR. TRAWLEY: We might make an inquiry

for you and supply that in an orderly fashion. We will

the tender system.

COMMISSIONER FIRSTONE: Assuming we

get the information and I am more concerned about the



1 principles rather than the names and addresses, is there
2 a requirement requiring hospitals to call for tender or
3 use the tender system?

4 HON. DR. ROSS: No, I don't think there is any. We
5 haven't anything in our regulations that requires tenders
6 being called.

7 MR. CAMPBELL: Are you talking about operating supplies
8 where the size of the operation - other than any current
9 operation for constriction, for example?

10 COMMISSIONER FIRESTONE: I am referring to drugs,
11 tenders for drugs.

12 HON. DR. ROSS: Not in our regulations.

13 COMMISSIONER FIRESTONE: Well now, sir, you have made
14 a very convincing case that the tender system is a wonder-
15 ful system. It brings you the greatest economies. You
16 leave it to the discretion of the hospitals whether they
17 use the tender system or not. If you are convinced the
18 tender system is a good system what stands in the way of
19 making the tender system obligatory for the larger hospitals?

20 HON. DR. ROSS: I would think, Dr. Firestone, that we
21 have some 105 hospitals throughout the Province of Alberta,
22 many of them small ones. The larger drugs are bought in
23 large quantities, usually from wholesale houses. They may
24 find they run short and they go to the local drugstore to
25 buy them. There is kind of a local, I suppose, spirit of
26 co-operation that is nice to see existing in a community,
27 and this relates to their operation, but it is a relatively
28 small scale.

29 For the larger metropolitan hospitals
30 where there are quantities up in the thousands, then I
31 think that this could be asked of them. We would feel
32 this is something however with our relationship with the
33 Associated Hospitals of Alberta, which is the body
34 that represents the hospitals should be discussed with



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4 them to see whether they would feel that this is of
5 advantage and desirable for the hospitals they represent.
6 In our regulations we attempt, as far as possible, to
7 have a mutual and satisfactory discussion before any
8 regulation goes into effect in order that the economy
9 of these hospitals is maintained and not being directed
10 in its day-to-day activities by government.

11 COMMISSIONER FIRESTONE: As I under-
12 stand it, Mr. Minister, you are in favour of the proce-
13 dure but before you do it you want to consult the people
14 affected.

15 HON. DR. ROSS: That is right.

16 COMMISSIONER FIRESTONE: If this consul-
17 tation takes place and it gives results would it be
18 possible to communicate the results to us if they are
19 not of a confidential nature?

20 HON. DR. ROSS: It is public business.
21 It is not of a confidential nature.

22 COMMISSIONER FIRESTONE: Thank you very
23 much. We would be very happy to receive it.

24 Mr. Frawley, during an answer to a
25 question a little earlier you mentioned some of the
26 difficulties that are encountered, if I understand you,
27 and please correct me if I am wrong, if I didn't under-
28 stand you correctly, may be due to the Food and Drug Act,
29 the present wording and method of administration of the
30 Act. Now, if this is the case and without asking you
for a specific answer at the moment, would it be possible
to let us have suggestions for possible amendments to
the Food and Drug Act and any change in regulations and

them to see whether they would feel that this is an
 advantage and desirable for the hospitals they represent.
 In our regulations we attempt, as far as possible, to
 have a mutual and satisfactory discussion before any
 regulation goes into effect, in order that the economy
 of these hospitals is maintained and not being directed
 in its day-to-day activities by government.

COMMISSIONER FLETCHER: As I understand it, Mr. Minister, you are in favor of the pro-

posed and before you do it you want to consult the people

HOW. DR. 1922: That is right.

COMMISSIONER FLETCHER: If this consul-

tation takes place and it gives results would it be
 possible to communicate the results to us? They are
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HOW. DR. 1922: It is public business.

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much. We would be very happy to reserve it.

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 stand you correctly, may be due to the Food and Drug Act,
 the present working and method of administration of the
 Act. Now, if this is the case and without asking you
 for a specific answer at the moment, would it be possible
 to let us have suggestions for possible amendments to
 the Food and Drug Act and any change in regulations and



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3 operations under the Act to make the Act more effective
4 and the reasons for the change suggested.

5 MR. FRAWLEY: Thank you. I would
6 certainly try to do that, sir.

7 COMMISSIONER FIRESTONE: Thank you very
8 much. I will come now to my last question, Mr. Frawley,
9 and this is relating to page 115, paragraph 379 in
10 which you recommend the set-up of a federal agency to
11 be concerned with matters of drug cost and information
12 relating to various aspects which you enumerated in
13 paragraph 4, sub-paragraph (i) to (iv). Now, sir, I
14 take it that a federal agency as you visualize could be
15 an extension of the Food and Drug administration or the
16 National Drug Council. If there is such a national
17 drug council rather than a departmental agency, I pre-
18 sume you will want to have on such council representatives
19 of various interested groups. I would like to suggest
20 to you some possibilities, and please indicate to me
21 whether that is what you had in mind. I would visualize,
22 for example, such a national drug council may have repre-
23 sentatives from the medical profession, from the pharma-
24 ceutical profession, from hospital administrators, from
25 drug manufacturers, from drug distributors, provincial
26 governments and the consuming public as well as, of
27 course, the government primarily concerned with the
28 agency. Is that the sort of council or agency you had
29 in mind when you said here in this paragraph, in sub-
30 section 4, a federal agency with power and direction?

MR. FRAWLEY: Frankly, Dr. Firestone,
your list is a little frightening. I think if those



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operations under the Act to make the Act more effective
and the reasons for the change suggested.

certainly try to do that, sir.

COMMISSIONER FIVELAND: Thank you very
much. I will come now to my last question, Mr. Fiveland,
and this is relating to page 11, paragraph 30 in
which you recommend the setting up of a federal agency to
be concerned with matters of drug cost and information
relating to various aspects which you enumerated in
paragraph 29, sub-paragraph (1) to (iv). Now, sir, I
take it that a federal agency as you visualize could be
an extension of the Food and Drug Administration or the
National Drug Council. If there is such a national
drug council, cannot that a departmental agency, I pre-
sume you will want to have a national representative
of various interested groups. I would like to suggest
to you some possibilities, and please indicate to me
whether that is what you had in mind. I would visualize,
for example, such a national drug council may have repre-
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governments and the consuming public as well as, of
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in mind when you said here in this paragraph, in sub-
section 4, a federal agency with power and direction?



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3 various organizations were to be represented it might
4 become rather an unwieldy body. That would be my first
5 objection to it. Frankly, you see, what is suggested
6 is that it would be - it would have two or three
7 functions. I would think that the first function to
8 examine the revenue cost position, one chartered
9 accountant would be quite sufficient, perhaps, to look
10 after that.

11 Now, I would think there would have to
12 be some representative of the medical profession, not
13 that he would be representing the medical profession,
14 but some knowledgeable person that would know, that
15 would be able to make evaluation of new drugs, modifica-
16 tions and combinations, and the same person might be
17 able to discharge the obligations which are set out in
18 Roman three, to encourage the wide use of generic drugs.

19 Roman four, of course, seems to contain
20 the allegation and I would like to dispel any thought -
21 I wouldn't want to leave any thought with the Commission
22 that I am pointing a finger at the Patent Act or the
23 Food and Drug Act, that it isn't doing its job. It is
24 doing its job as it has been enacted by Parliament and
25 administered by the administration. I am only just
26 suggesting again that it would be helpful to have an
27 assurance that the Patent Act wasn't being abused. I
28 think it is not too rash a thing to say it is possible
29 the Patent Act might be abused. That is all. I am
30 suggesting this body which is to be created perhaps to
do two things, to review the revenue cost position and
to evaluate the new drugs. Attached to those powers



various organizations were to be represented it might become rather an unwieldy body. That would be my first objection to it. Frankly, you see, what is suggested is that it would be - it would have two or three functions. I would think that the first function is examine the revenue cost position, one charged account would be quite sufficient, perhaps, to look at.

Now, I would think there would have to be some representative of the medical profession, not that he would be representing the medical profession, but some knowledgeable person that would know, that would be able to make evaluation of new drugs, modifications and combinations, and the same person might be able to discharge the obligations which are set out in Roman three, to encourage the wide use of generic drugs.

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3 could very well be a further one, to see there is no
4 possibility of any abuse of the Patent Act or the Food
5 and Drug regulations.

6 I must be very careful to state at the
7 moment I am not suggesting there is any abuse. I know
8 there are formidable requirements for the introduction
9 of new drugs by the Food and Drug Directorate. I am not
10 to say those are not warranted. I simply point out as
11 a result of them we have this paucity of sale of generic
12 drugs.

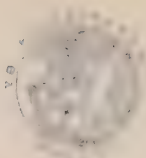
13 COMMISSIONER FIRESTONE: These functions,
14 this might be done by an extension of the operation of
15 the Food and Drug administration.

16 MR. FRAWLEY: Yes, it might be done in
17 the general agency of the Food and Drug Act. You see,
18 when you get into examination of revenue cost position,
19 then you are getting into something the Minister of
20 Health doesn't want to have anything to do with, and
21 shouldn't, perhaps be asked to have anything to do with.

22 There should be some other federal
23 agency that would be glad to do it. I wouldn't think
24 it would be too difficult. They are discharging functions
25 now not too distinct from that.

26 COMMISSIONER FIRESTONE: Have you a
27 specific proposal to make or suggestion - you realize
28 this question of economics may have certain far-reaching
29 importance on the industries concerned?

30 MR. FRAWLEY: I know in the Department
of Trade and Commerce, of which you were certainly an
honoured member at the time when you were there, they



could very well be a further one, to see there is no possibility of any abuse of the Patent Act or the Food and Drug Regulations.

It must be very careful to state at the moment I am not suggesting there is any abuse. I know there are formidable requirements for the introduction of new drugs by the Food and Drug Directorate. I am not to say those are not warranted. I simply point out as a result of them we have this paucity of sale of generic drugs.

COMMISSIONER FRAWLEY: These functions this might be done by an extension of the operation of the Food and Drug Administration. MR. FRAWLEY: Yes, it might be done in the general agency of the Food and Drug Act. You see, when you get into examination of average cost testing, then you are getting into something the Minister of Health doesn't want to have anything to do with, and shouldn't, perhaps be asked to have anything to do with. There should be some other Federal agency that would be glad to do it. I wouldn't think it would be too difficult. They are discouraging functions now not too distant from that.

COMMISSIONER FRAWLEY: Have you a specific proposal to make or suggestion - you realize this question of economics may have certain far-reaching importance on the industries concerned?

MR. FRAWLEY: I know in the Department of Trade and Commerce, of which you were formerly an honoured member at the time when you were there, they



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3 are discharging functions that are not, as I said before,
4 too distantly related to the kind of thing I have in
5 mind. More specifically than that, I think it would be
6 rash for me to go on.

7 COMMISSIONER FIRESTONE: Would you
8 visualize an advisory body? The reason I mention these
9 various groups is that industry may feel, the drug
10 industry, the drug distributors, may feel they have to
11 have some say in this connection, as to the kind of
12 advice that is being employed and what have you, and
13 that perhaps an advisory body would achieve the objective
you have in mind.

14 MR. FRAWLEY: I would think to achieve
15 what I have in mind we would need to go very far beyond
16 the advisory concept.

17 COMMISSIONER FIRESTONE: If I may
18 summarize in my own words my understanding of these
19 four sub-paragraphs, this agency would (a) conduct
20 studies dealing with the problems, manufacture, cost
21 and prices of drugs. You would look not only on domestic,
but also on imported drugs; is that correct?

22
23 MR. FRAWLEY: That is correct.

24 COMMISSIONER FIRESTONE: Secondly, it
25 would form an advisory function to government?

26 MR. FRAWLEY: May I correct you, because
27 I don't visualize any examination of cost in Europe. I
think the starting point would be here.

28 COMMISSIONER FIRESTONE: Cost in Canada.

29 MR. FRAWLEY: Cost in Canada.
30



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MR. FRAWLEY: Yes, I correct you, because
I don't visualize any examination of cost in Europe. I
think the starting point would be here.
COMMISSIONER FRASER: Cost in Canada.



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4 COMMISSIONER FIRESTONE: That is a
5 useful correction. The second function would be an
6 advisory function to government, whether it was changes
7 in legislation, the Patent Act or the Food and Drug Act
8 or any other regulation, it would be an advisory function
to the Government; am I correct?

9 MR. FRAWLEY: That is correct.

10 COMMISSIONER FIRESTONE: The third
11 function would be an information function to the medical
12 profession, to hospitals, to the drug industry and to
drug distributors.

13 MR. FRAWLEY: Yes, and that is the pur-
14 pose of endeavouring to find if some savings cannot be
15 made in the large marketing costs.

16 COMMISSIONER FIRESTONE: I take it those
17 studies would be made public so that the public would
18 have knowledge of the fact?

19 MR. FRAWLEY: Oh, yes.

20 COMMISSIONER FIRESTONE: Also they
21 would have a certain educational effect both on suppliers
as well as users?

22 MR. FRAWLEY: Certainly the information
23 gathered under Roman two would be made public. That
24 would be its purpose, to give information. With respect
25 to the revenue cost position, whether that would be
made public...

26 COMMISSIONER McCUTCHEON: That is a
27 much more difficult question.

28 COMMISSIONER FIRESTONE: I know it is
29 more difficult. It is one on which we would like to have
30



useful correction. The second function would be an advisory function to government, whether it was changes in legislation, the Patent Act or the Food and Drug Act or any other regulation, it would be an advisory function to the government; am I correct?

function would be an information function to the medical profession, to hospitals, to the drug industry and to

MR. TRAWLEY: Yes, and that is the purpose of endeavouring to find out what savings cannot be made in the large marketing costs.

COMMISSIONER FIBBS: I take it those studies would be made public so that the public would have knowledge of the facts?

MR. TRAWLEY: Of, yes.

COMMISSIONER FIBBS: Also they would have a certain educational effect both on suppliers as well as users?

MR. TRAWLEY: Certainly the information gathered under Point two would be made public. That would be its purpose, to give information, with respect to the revenue cost position, whether that would be made public...

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COMMISSIONER FIBBS: I know it is more difficult. It is one on which we would like to have



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2
3 your views, Mr. Frawley. If you wish to consider the
4 question and let us have the answer at a subsequent
5 time it is all right.

6 MR. FRAWLEY: I don't want to assume a
7 too reluctant role at all. I wasn't at all reluctant
8 in asking Cyanamid to put it on the record before the
9 Restrictive Trade Practices Commission.

10 COMMISSIONER McCUTCHEON: They weren't
11 reluctant to decline?

12 MR. FRAWLEY: They were equally reluc-
13 tant. It doesn't seem to me there is anything very
14 reprehensible if everybody did it, if everybody's costs
15 were put forward. I know I am invading a business area
16 and without looking in Mr. McCutcheon's direction, I
17 think there would be continued reluctance to disclose
18 that cost revenue position and I might have to be quite
19 content for the purpose I have suggested that it shouldn't
20 be made public. I don't think it would be meaningless.

21 COMMISSIONER FIRESTONE: You cannot
22 visualize some other studies by combining the cost and
23 showing averages for the industry or the drug and that
24 would really not divulge the operations of a particular
25 company?

26 MR. FRAWLEY: I can't.

27 COMMISSIONER FIRESTONE: Would that
28 have some salutary effect in publishing that type of
29 information?

30 MR. FRAWLEY: I can't make that too
clear, if that is all that is going to come out, an
analysis of all the drugs, I think that would be useless



your views, Mr. Crawley. If you wish to consider the question and let us have the answer at a subsequent time it is all right.

MR. CRAWLEY: I don't want to assume a too reluctant role at all. I wasn't at all reluctant in asking (yesterday) to put it on the record before the Restrictive Trade Practices Commission.

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3 for the kind of thing I am discussing at the moment.

4 COMMISSIONER FIRESTONE: You would be
5 interested in the specific drugs, if there were several
6 manufacturers of the same drug and their costs were
7 combined would you see some difficulty in that?

8 MR. FRAWLEY: It would be averaged.

9 COMMISSIONER FIRESTONE: Yes, in order
10 not to disclose information. You know this is the prin-
11 ciple, it is a principle that is fairly legitimate with
12 business and one would want to respect it.

13 MR. FRAWLEY: We might have to accept
14 that. We might have to accept that and go on to see to
15 what extent it might improve it.

16 COMMISSIONER FIRESTONE: Thank you very
17 much. You have not only not played a reluctant role,
18 but you have been most helpful, sir.

19 THE CHAIRMAN: Thank you, Dr. Ross.
20 Unless you wish to make some closing statement or some
21 of your associates wish to say something...

22 HON. DR. ROSS: I don't know whether
23 there is anyone here who wants to make any statement.
24 I would like to say, sir, we have appreciated the oppor-
25 tunity of presenting this information to you, and we
26 have appreciated the questioning that all of your
27 members have made to us in attempting to enlighten your-
28 selves upon what we think is a most important Commission
29 investigation. If there is any way that we might help
30 you that you think of after you have left here, we
would be only too happy to supply any further information
that you would like to have and that we have available



For the kind of thing I am discussing at the moment.
COMMISSIONER FLEETWOOD: You would be
interested in the special drugs, if there were several
manufacturers of the same drug and their costs were
combined would you see any difficulty in that?
MR. FLEETWOOD: It would be avoided.
COMMISSIONER FLEETWOOD: Yes, in order
not to disclose information. You know this is the prin-
ciple, it is a principle that is fairly legitimate with
business and one would want to respect it.
MR. FLEETWOOD: We might have to accept
that. We might have to accept that and go on to see to
what extent it might improve it.
COMMISSIONER FLEETWOOD: Thank you very
much. You have not only played a reluctant role,
but you have been most helpful, sir.
Unless you wish to make some clearing statement on some
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HOW, MR. FLEETWOOD: I don't know whether
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selves upon what we think is a most important commission
investigation. If there is any way that we might help
you that you think of after you have left here, we
would be only too happy to supply any further information
that you would like to have and that we have available



for you.

On behalf of all my colleagues here
I would like to thank you once again.

THE CHAIRMAN: Thank you very much,
Dr. Ross. I must say I think it has been a very profi-
table, if a long, day. I wish that you would, on our
behalf, take to Premier Manning our thanks for his
message of welcome this morning and his regret at not
being able to be here.

HON. DR. ROSS: Thank you very much.

THE CHAIRMAN: We will rise until nine
tomorrow when we will proceed with the submission of the
Victorian Order of Nurses.

--- Adjournment.



for you.

On behalf of all my colleagues here

I would like to thank you once again.

THE CHAIRMAN: Thank you very much.

Mr. Ross, I must say I think it has been a very profit-

table, if a long, day. I wish that you would, on our

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HON. DR. ROSS: Thank you very much.

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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

EDMONTON

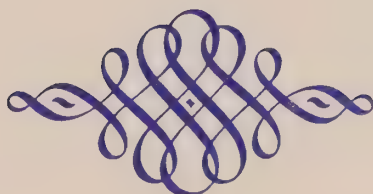
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VOLUME NUMBER :

23

DATE :

FEBRUARY 13 1962



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I N D E X

Submission of the Victorian Order of Nurses
for Alberta

Brief

Submission of the Academy of Religion and
Mental Health, Calgary Branch

Brief

Submission of the University of Alberta
Faculty of Dentistry

Brief

Evidence

Submission of the Alberta Pharmaceutical
Association

Brief

Evidence

Submission of the Chaplaincy Advisory
Committee of the Calgary General Hospital

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Submission of the Victorian Order of Nurses
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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held in Edmonton, Alberta,
13th day of February, 1962.

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL-Chairman

MISS ALICE GIRARD, R.N.

DR. DAVID M. BALTZAN

PROF. O. J. FIRESTONE

MR. M. WALLACE McCUTCHEON, Q.C.

DR. C. L. STRACHAN

DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R. N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. N. LAFRANCE



PROCEEDINGS OF THE HEARING

ON THE MATTER OF THE
HONORABLE ARTHUR P. VAN NORT

COMMISSION ON

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THE MATTER OF THE

C. E. STEPHENSON

ARTHUR P. VAN NORT

COMMISSION ON

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THE MATTER OF THE



Edmonton, Alberta,
Tuesday,
February 13, 1962.

--- On commencing at 9.00 a.m.

THE CHAIRMAN: We shall now proceed
this morning with the submission from the Victorian Order
of Nurses for Alberta.

--- EXHIBIT NO. 113: Submission of the
Victorian Order of
Nurses for Alberta.

SUBMISSION

of

VICTORIAN ORDER OF NURSES FOR ALBERTA

APPEARANCES:

MR. H. C. MANTZ,

MR. F. FRITZ, President of Medicine
Hat Branch

MRS. A. C. McWILLIAMS, representing Calgary
Branch

MRS. J. E. PETERSON, President of Edmonton
Branch

MISS C. SWINTON, Regional Director

MRS. I. A. SHAPIRO, President of Lethbridge
Branch

MR. MANTZ: Mr. Chairman, first of all
I would like to introduce the committee who are with me
today.

On my right is Mrs. Iris Albert Shapiro,
President of the Lethbridge Branch. Next to her is Mr.

February 13, 1952.

--- On commencing at 9.00 a.m.

THE CHAIRMAN: We shall now proceed

this morning with the submission from the Victorian Order

EXHIBIT NO. 113: Submission of the
Victorian Order of

SUBMISSION

of

VICTORIAN ORDER OF MERITS FOR ALBERTA

ATTENDANCE:

MR. H. G. MANTON,

the French

MRS. A. G. MONTAGNA, representing Calgary

MRS. J. E. HENDERSON, President of Edmonton

MRS. C. SUTTON, Regional Director

MRS. I. A. SHAPRO, President of Lethbridge
Branch

MR. MANTON: Mr. Chairman, first of all

I would like to introduce the committee who are with me

today.

On my right is Mrs. Iris Albert Shaprow,

President of the Lethbridge Branch. Next to her is Mr.



1 F. Fritz, president of the Medicine Hat Branch, Mrs. A.
2 C. McWilliams, representing the Calgary Branch. And on
3 my immediate right, Mrs. J. E. Peterson, president of the
4 Edmonton Branch. On my immediate left, the Regional
5 Director, Miss Swinton.

6 Now, if I may, Mr. Chairman, I will read
7 the summary of the brief.

8
9 SUMMARY

10 1. The Victorian Order service has been available
11 to people in Alberta since the founding of the organization
12 more than 60 years ago. Cottage hospitals helped to meet
13 the need for hospital service in the isolated communities
14 until such time as the provincial government assumed
15 responsibility for these services.

16 2. The development of branches has followed
17 the population growth of the larger cities where the need
18 for service became apparent and the financial support was
19 more readily available. At the present time the four
20 branches in Alberta, located in Edmonton, Calgary,
21 Medicine Hat and Lethbridge, serve 51% of the population of
22 the province.

23 3. Victorian Order service in Alberta is
24 predominantly a visiting nursing program for the care of
25 ill persons in their own homes. From the records of
26 medical and surgical patients dismissed in 1960 it is
27 significant that 54% of these patients had conditions
28 classified as chronic or long-term in nature and accounted
29 for 87% of the visits. This trend, together with an
30 increase in the number of elderly patients admitted for



1. F. Fritz, president of the Medicine Hat Branch, Mrs. A.
2. C. McWilliams, representing the Calgary Branch. And on
3. my immediate right, Mrs. J. E. Peterson, president of the
4. Edmonton Branch. On my immediate left, the Regional
5. Director, Miss Swanton.
6. Now, if I may, Mr. Chairman, I will read
7. the summary of the paper.

more than 50 years ago. Cottage hospitals helped to meet
the need for hospital service in the isolated communities
until such time as the provincial government assumed
responsibility for these services.
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the population growth of the larger cities where the need
for service became apparent and was financially supported
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branches in Alberta, located in Edmonton, Calgary,
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the province.
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predominantly a visiting nursing program for the care of
ill persons in their own homes. From the records of
medical and surgical patients admitted in 1950 it is
significant that 5% of these patients had conditions
classified as chronic or long-term in nature and accounted
for 87% of the visits. This trend, together with an
increase in the number of elderly patients admitted for



1 service, has been experienced in all the branches.

2 4. ~~and the~~ Group prenatal teaching is carried out in

3 three branches. These programs have been developed in

4 co-ordination with the departments of health and other

5 health agencies.

6 5. ~~The~~ The Victorian Order in Alberta is inter-

7 ested in the development of new programs within the

8 existing branches. Referral programs have been established

9 in two branches, one in Medicine Hat in the Municipal

10 Hospital, the other in the Calgary General Hospital. This

11 method of ensuring continuity of patient care has proven

12 successful and could be developed in the active treatment,

13 auxiliary and rehabilitation hospitals in all the branches.

14 The interest in the development of organized home care

15 in Calgary has been supported by the Calgary branch. The

16 Council of Community Services in Calgary has, for the past

17 two years, been active in the planning of a proposed

18 home care program. The Victorian Order in Calgary has

19 participated in the planning and has been asked to

20 administer the proposed project. A brief outlining the

21 program, with a request for financial support, has been

22 prepared for submission to the provincial government.

23 The Victorian Order is giving leadership in this program

24 and is willing to participate in other similar developments.

25 6. New branches of the Order could be

26 established in other centres in the province where there

27 is sufficient population to support a service. Requests

28 for service have been received from Taber, Vauxhall and

29 Red Deer. A branch at Red Deer could be developed to

30 serve the urban area and extended to include several



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25 established in other centres in the province where there

26 is sufficient population to support a service. Requests

27 for service have been received from Taber, Vauxhall and

28 Red Deer. A branch at Red Deer could be developed to

29 serve the urban area and extend to include several



1 small towns and villages in the area. There would be the
2 advantage of service for a larger population without the
3 unnecessary costs of organizing small branches. An
4 extension of the branches at Edmonton and Lethbridge would
5 also make service available to smaller communities within
6 practical geographic limits of the established branch.

7 7. The large number of government assistance
8 cases at present receiving service from the Order are
9 generally unable to pay the fee for service. This has
10 strained the financial resources in each branch. Payment
11 for visiting nursing on a fee for service basis for
12 persons who are receiving social allowance or social
13 assistance through welfare legislation would seem to be
14 a reasonable responsibility of government. Although a
15 provincial government grant is received this pays only a
16 small proportion of the cost of service to these patients.
17 New sources of income for financing the cost of the service
18 in the branches would enable them to further develop and
19 extend Victorian Order service in Alberta.

20 8. The Victorian Order is willing to partici-
21 pate in any program that will ensure adequate health care
22 and in particular visiting nursing care to the people of
23 Alberta.

24 That, sir, is the summary.

25 THE CHAIRMAN: Thank you very much.

26 Miss Girard?

27 COMMISSIONER GIRARD: Yes, Mr. Chairman.

28 I have a few questions.

29 First of all, you talk about the planning
30 of a home care programme. There has been a two year



1 planning period. There seems to be adequate amount of
2 time. Do you have any idea of when this will start, or
3 what is holding it up, or is there anything in the way
4 of developing a home care programme?

5 MR. MANTZ: I would like to ask Mrs.
6 McWilliams from Calgary to answer that question.

7 MRS. McWILLIAMS: Well, we have had
8 one in service for about a year now in the Calgary General,
9 and they pay the nurse who does the work in the hospital.
10 She works three hours per day, five days a week.

11 Now, what we are trying to do is extend
12 this service, and this is on a trial basis.

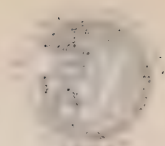
13 COMMISSIONER GIRARD: You mean you are
14 trying to extend the referral programme to a home care
15 programme; is this correct?

16 MRS. McWILLIAMS: Yes. Well, the
17 referral -- the nurse in the hospital goes through and she
18 contacts those patients who are able to go home, and then
19 we provide the nursing services.

20 COMMISSIONER GIRARD: Yes. I notice
21 that the referral programme as it was done here was a
22 little bit more extensive than some other referral programmes
23 in some other V.O.N. branches in the fact that the nurse
24 not only has her office in the hospital, but she goes
25 through the hospital. Is this right, Miss Swinton? It is
26 a little more extensive?

27 MRS. McWILLIAMS: Yes.

28 COMMISSIONER GIRARD: So this is a
29 referral programme that you would like to enlarge to a
30 home care programme?



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COMMISSIONER GIRARD: So this is a

referral programme that you would like to enlarge to a

home care programme?



1 MISS SWINTON: I think the referral
2 programme has been the starting point, but it has gone
3 further than this. The Council of Services in Edmonton
4 has been instrumental in calling all the community agencies
5 together on a community basis home care programme. This
6 programme was planned and the budget submitted through
7 the provincial government with the hope of getting a health
8 grant from the federal government to finance the project.
9 It has been re-written and re-submitted and the hold up
10 at the moment is the fact it has to be cleared through
11 the provincial Department of Health, and if a National
12 Health grant is secured, this is where the thing is broken
13 down at this point.

14 COMMISSIONER GIRARD: As far as the
15 V.O.N. is concerned, the V.O.N. would be ready to go into
16 this home care plan?

17 MISS SWINTON: Yes.

18 COMMISSIONER GIRARD: This seems
19 important to me in view of the fact you also say in your
20 brief that the auxiliary hospitals will hurt the V.O.N.
21 because they will be taking cases from the general hospitals
22 that normally you would expect the V.O.N. to be taking;
23 is this correct?

24 MISS SWINTON: That is true. It is our
25 experience in the auxiliary hospital that this institution
26 has been able to relieve the active treatment hospital,
27 and before one was opened in Calgary a referral programme
28 was demonstrating that people could be moved from the
29 hospital to their own home environment. But once the
30 home hospital was opened, referrals dropped to nothing.



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1 It appeared to be a trend to move patients from one
2 institution to another and forget about the community to
3 which we hoped patients could be returned.

4 Our concern is that we need the closest
5 liaison in the auxiliary hospital, where you have the
6 chronic and convalescent hospital, perhaps even more so
7 than the active treatment hospital. These are the people
8 we hope eventually to return to the community.

9 COMMISSIONER GIRARD: Could you even-
10 tually see you could have a home care plan in relation to
11 the auxiliary hospitals?

12 MISS SWINTON: Indeed, we do.

13 COMMISSIONER GIRARD: Even more than
14 with the general hospitals?

15 MISS SWINTON: Yes, I think this is
16 the greatest need at the moment.

17 COMMISSIONER GIRARD: Is this in your
18 plan for home care? Has this particular been taken care
19 of in the programme or plan you have submitted?

20 MISS SWINTON: This is the basis of
21 our programme, that there be a strong referral programme
22 in active treatment hospitals and the auxiliary hospital
23 be the basis for further planning into the organized, as
24 we say, community home care programme.

25 COMMISSIONER GIRARD: As I noticed
26 somewhere else in this brief, you mention the number of
27 cases had gone down -- the number of referral cases, from
28 twenty to thirty to seven, I believe.

29 MISS SWINTON: That is right.

30 COMMISSIONER GIRARD: Is this really



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1 hurting, or is it doing something to your programme?

2 MISS SWINTON: We feel there is probably
3 a trend towards institutional care.

4 COMMISSIONER GIRARD: What would be the
5 possibility of extending it from Calgary to other branches?

6 MISS SWINTON: Well, I think, Mr.
7 Chairman, that our problem in this programme is a question
8 of finance. We have the staff; we feel we have the staff,
9 and we have the experience to develop this programme, but
10 the local branch has not the resources to extend service
11 into an institution and pay for it out of community funds.
12 And, in the province of Alberta, our fund-raising has
13 almost reached its limit. In fact, this year several of
14 our branches did not receive their quota from the fund-
15 raising agencies. So that we do not have the funds to
16 put people into the institutions as we would like to, and
17 until we can get these financial resources we have reached
18 an impasse.

19 COMMISSIONER GIRARD: I notice in your
20 resources, twelve per cent of the total income comes from
21 municipal grants, nine per cent from provincial grants,
22 twenty-six per cent of all money is from nursing fees, and
23 the rest, fifty-three per cent, is raised through
24 community appeals.

25 Is not the twenty-six per cent for fees
26 low? You will recall that some branches have a much higher
27 percentage of their income coming from fees.

28 Do you recall seeing a number of branches
29 with this? Am I right?

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25 percentage of their income coming from fees.

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27 with this? Am I right?

28 MISS SWINTON: Mr. Chairman, I think so.



1 fees in Alberta relate very directly to the payment --
2 the non-payment for government assistance cases. In the
3 other branches, our total fees, the collection from all
4 sources, is higher.

5 COMMISSIONER GIRARD: Yes, I thought so.

6 MISS SWINTON: But we receive consider-
7 able funds from our direct payment on a fee for service
8 basis on the ~~government~~ assistance cases. In Alberta, we
9 have not this arrangement, so the government assistance
10 cases must be absorbed by the local branch as free service,
11 so our fees are very much lower as a consequence.

12 COMMISSIONER GIRARD: This appeared to
13 be where the gap was in your receiving of funds in this
14 area of all the service you give to the assistance cases
15 without getting any return. Do you feel that way?

16 MISS SWINTON: I think this year --
17 the first eleven months of this year, over sixty per cent
18 of our service is to government assistance cases for which
19 we receive no revenue, or very little.

20 THE CHAIRMAN: Why do you do it?

21 COMMISSIONER GIRARD: Have you ever asked
22 for it?

23 THE CHAIRMAN: Is the Government of
24 Alberta not able to pay?

25 MISS SWINTON: Mr. Chairman, our basic
26 principle in the Victorian Order is to give service.

27 THE CHAIRMAN: To give service to those
28 who are unable to pay.

29 MISS SWINTON: We have been negotiating
30 -- I think it is unfair to say we get no grant. We do get



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I think it is unfair to say we get no grant. We do get



1 a \$10,000.00 grant, which accounts for ninety per cent of
2 our revenue. We are hoping, and I think it would be a
3 reasonable responsibility of the government to assume the
4 cost for this.

5 The new legislation in this province is
6 so written, in very broad terms, to improve the basic
7 necessities, and we hope that visiting nursing is a basic
8 necessity, and we could work out some arrangement.

9 THE CHAIRMAN: Are you being asked to
10 do that?

11 MISS SWINTON: Are we being asked to
12 give the service, sir?

13 THE CHAIRMAN: Yes.

14 MISS SWINTON: Yes.

15 THE CHAIRMAN: Well, I would put a price
16 tag on it.

17 COMMISSIONER McCUTCHEON: You want to
18 enter what the Minister described yesterday as a mutual
19 agreement.

20 MISS SWINTON: Mr. Chairman, this is
21 what we have been working at some time. I do think this
22 is the area that we have to explore.

23 COMMISSIONER GIRARD: Do you have any
24 federal contributions?

25 MISS SWINTON: Only through national
26 contracts with the Department of Veterans Affairs and
27 other national insurance companies and so on on a fee
28 for service basis.

29 COMMISSIONER GIRARD: I have no more
30 questions, thank you.



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26 questions, thank you.



1 THE CHAIRMAN: You mentioned the
2 national health grants negotiating for, or rather there
3 was some discussion about it. Are the grants now avail-
4 able, and is it a matter of qualifying to receive them?
5 Or, is it a matter of having the department set up a new
6 grant?

7 MISS SWINTON: Mr. Chairman, in my
8 understanding, the National Health and Welfare have grants
9 available.

10 THE CHAIRMAN: They have funds?

11 MISS SWINTON: Specifically for home
12 care programmes. At the moment, I am working under that
13 arrangement in another province.

14 THE CHAIRMAN: It is a matter of
15 qualifying to get some of this money which is now available?

16 MISS SWINTON: The grants are made
17 available on the basis of organization of services.
18 Apparently this is the manner in which they prefer to pay
19 out the money. We have to submit through the local
20 provincial government to receive these funds.

21 THE CHAIRMAN: You say on page 2 of your
22 summary that the Victorian Order in Calgary had participated
23 in the planning and has been asked to administer the
24 proposed project, and a brief outlining the programme with
25 a request for financial support.

26 What support are you asking there? Is that
27 something that has already been committed to writing that
28 you could let us have a copy of?

29 MISS SWINTON: Mr. Chairman, the brief
30 outlines the administration and the cost of the programme



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2 case load -- for a period of one year, and the brief
3 contains the budget to cover the costs of this programme
4 for that period of time, and this is the brief that has
5 been submitted.

6 THE CHAIRMAN: Could we have a copy of
7 that brief.

8 MISS SWINTON: I think we could let you
9 have one, yes.

10 THE CHAIRMAN: Would you send it to Mr.
11 Lafrance?

12 MISS SWINTON: Yes, in deed.

13 THE CHAIRMAN: Now, I am interested in
14 your observation that you believed you had reached the
15 limit on your voluntary fund raising capacity.

16 Are you in a position to say whether the
17 fact that the government has taken over hospital costs and
18 is entering more and more into the financing of hospital-
19 ization and sickness -- is that having a bearing on the
20 trend in fund-giving?

21 MISS SWINTON: Mr. Chairman, I think
22 our branch president who has been negotiating with the
23 United Funds can answer this.

24 THE CHAIRMAN: Have you anything, Mrs.
25 McWilliams? Have you found there is resistance in the
26 public to voluntary giving because the government is taking
27 over more and more the responsibility for hospitalization
28 and sickness costs?

29 MRS. McWILLIAMS: Well, I think you are
30 correct in assuming that, if you are assuming it.



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1 THE CHAIRMAN: I am not assuming it,
2 no. I am looking for information.

3 MRS. McWILLIAMS: We are finding that
4 each time we go -- we are very fortunate in Calgary that
5 we reached our quota on community chest, and community
6 chest are very good to us, but we are finding in any one
7 who canvasses for anything -- and I have done a consider-
8 able amount -- that we meet a resistance. People say
9 "This is paid for", and "That is paid for by a government
10 agency...", or some other agency, so I do think there is a
11 resistance there.

12 There is so much government assistance
13 for this and that and the other thing, why should they
14 give too, they are giving double, you see.

15 COMMISSIONER BALTZAN: Does the V.O.N.
16 have a private appeal? Do they embark upon appeals on
17 behalf of the V.O.N., or do you make it through the
18 community chest?

19 MRS. McWILLIAMS: Ours are through the
20 community chest, and the grant we get from the provincial
21 government is divided between the four branches and the
22 city gives a grant, too. They give X-dollars to community
23 chest in Calgary themselves, and then the community chest
24 committee divides it amongst the different organizations.

25 COMMISSIONER BALTZAN: On the whole,
26 would you say your biggest problem probably is convincing
27 the community chest in the division of their collections;
28 or, is it inadequate response on the part of the individual
29 contributors in the community?

30 MRS. McWILLIAMS: Well, as I say, speaking



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agency...," or some other agency, so I do think there is a

resistance issue.

There is no such government resistance

for this and that and the other thing, why should they

give too, they are giving double, you see.

COMMISSIONER BURNHAM: Does the V.O.N.

have a private appeal? Do they embark upon appeals on

behalf of the V.O.N., or do you make it through the

community chest?

MRS. McWILLIAMS: Ours are through the

community chest, and the grant we get from the provincial

government is divided between the four branches and the

city, that is right, and they give X-dollar to community

chest and they give themselves, and then the community chest

committee divides it among the different organizations.

COMMISSIONER BURNHAM: On the whole,

would you say your biggest problem probably is convincing

the community chest in the division of their collections;

as it involves response on the part of the individual

contributions in the community?

MRS. McWILLIAMS: Well, as I say, speaking



1 for Calgary, we have made our quota there. I can hardly
2 complain about the Calgarians. Some of the other branches
3 may be able to speak of that who have been less fortunate.

B 4 MRS. SHAPIRO: Our experience this year,
5 rather for 1961, was that the Community Chest did not meet
6 their quota. We found resistance from the public to the
7 Community Chest, not that the Community Chest did not
8 want to give the different grants to different agencies
9 but they simply did not meet their quota and they did not
10 have the money.

11 MR. FRITZ: Likewise the United Fund
12 in Medicine Hat did not meet its objective and with the
13 result that I think seventy per cent was the amount they
14 arrived at, and consequently the agencies of the Fund had
15 to cut their budget accordingly.

16 MRS. PETERSON: In Edmonton we did
17 reach our quota and I think that we received the same
18 consideration as every other organization. However, there
19 are no funds available for expansion, and in our city
20 with its exploding population and the areas surrounding
21 Edmonton, I do not foresee any expansion in the next few
22 years. Of course, unless this is subsidized in some way,
23 especially the social assistance cases, then I think we
24 are going to remain quite static for the time being.
25 I do believe that the United Funds that are given by the
26 citizens of Edmonton are allocated according to need, but
27 it is getting more difficult each year to get the money
28 for capital or expansion.

29 COMMISSIONER VAN WART: Miss Swinton,
30 do you find that apartment house living is a detriment



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29 officers of Edmonton are allocated according to need, but
30 it is getting more difficult each year to get the money
31 for social or expansion.

32 do you find that apartment house living is a detriment



1 to the home care programme that you are speaking about?

2 MISS SWINTON: Most of our branches do
3 a considerable amount of work in the apartment type
4 dwelling and we have not found it too difficult. Again,
5 I think it depends on the co-ordination of other services
6 as to how right you can make conditions before you take
7 the patient home. This is the important part, that you
8 get the home situation in order before you move the
9 patient home. I do not think we have any particular
10 trouble with apartment dwellers.

11 COMMISSIONER VAN WART: Is space
12 available in apartments for a person to be properly
13 nursed?

14 MISS SWINTON: In our experience we have
15 not had any trouble. There are some branches that you
16 might call the slum areas where it may be more difficult
17 but not in the large branches in this province.

18 COMMISSIONER FIRESTONE: You mentioned
19 a little earlier that negotiations were underway between
20 the provincial government and the federal government to
21 get a grant under the home care programme. Would it be
22 possible for the V.O.N. of Alberta to advise this
23 Commission of the outcome of those communications and if
24 the provincial government run into difficulties and you do
25 not get the grant, could we be advised of that fact and
26 the reasons given? If you are given the grant could we
27 be advised whether the availability of such a grant for
28 Calgary would make it possible for you to expand your
29 programme to other areas in Alberta?

30 MISS SWINTON: We would be happy to get



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20 possible for the V.O.H. of Alberta to advance this

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22 the provincial government ran into difficulties and you do
23 not get the grant, could we be advised of that fact and
24 the reasons given? If you are given the grant could we
25 be advised whether the availability of such a grant for
26 Calgary would make it possible for you to expand your

27 programme to other areas in Alberta?
28 MISS SWINTON: We would be happy to get



1 that for you.

2 THE CHAIRMAN: Thank you very much.

3 As you know, we have had briefs from the V.O.N., I believe
4 this is the seventh province, and we are concerned as we
5 move from one province to another to be informed of
6 whether you have a different pattern. Now, is there
7 anything you want to add in that respect whether the
8 pattern of your work in Alberta differs from that that
9 we have been told about in the other provinces which we
10 are already aware of?

11 MISS SWINTON: I do not think fundamen-
12 tally there is a great difference. I think the important
13 difference is the fact that we do a great deal of work
14 with the chronically ill long-term patient in this province;
15 proportionately we appear to be doing more than the two
16 other Prairie provinces.

17 THE CHAIRMAN: Thank you very much. We
18 are grateful to this delegation and to the V.O.N. for your
19 attendance here and for the information that you have
20 given us.

21 MR. FRITZ: Mr. Chairman and members of
22 the Commission, on behalf of the four established branches
23 of the V.O.N. and the V.O.N. in general I would like you
24 to know that we appreciate you having heard our submission
25 this morning.

26 THE CHAIRMAN: Now, we have the submission
27 from the Academy of Religion and Mental Health; is there
28 anyone here to speak to this submission?

29 THE SECRETARY: In the absence of this
30 group, Mr. Chairman, I would suggest the brief be filed



1 with the Commission as Exhibit 114, and that the
2 recommendations contained in page 4 of the brief be placed
3 in the record as they are on that page.

4 THE CHAIRMAN: It may well be that the
5 reason they are not here at the moment is that were on the
6 programme for yesterday afternoon and we did not reach
7 them. In any event, we can say for the record now that
8 the recommendations particularly on page 4 will be directed
9 to the Medical Education Project so that the views of this
10 Academy may be before the Medical Education Project
11 Committee in their deliberations. The brief as such will
12 be received as Exhibit 114.

13

14 --- EXHIBIT NO. 114: Submission of Academy
15 of Religion and Mental
16 Health, Calgary Branch.

17

18 RECOMMENDATIONS

19 1. The Commission is requested to consider
20 recommending that:

21 The Schools of Medicine

22 (a) rethink the nature of man and his status in a
23 technological culture. "THE NATURE OF MAN in
24 Theological and Psychological Perspective" is
25 just off the press. It is edited by Simon
26 Doniger and includes contributions from such
27 eminent thinkers as Paul Tillich, Karl Menninger,
28 Karen Horney, Carl Rogers, Seward Hiltner,
29 Franz Alexander and seventeen others. This book
30 will bear thorough study and is available from



THE CHAIRMAN: It may well be that the reason they are not here at the moment is that were on the programme for yesterday afternoon and we did not reach them. In any event, we can say for the record now that the recommendations particularly on page 11 will be directed to the Medical Education Project so that the views of this Academy may be before the Medical Education Project Committee in their deliberations. The brief as such will be received as Exhibit 11A.

Submission of Academy
of Religion and Mental
Health, Calgary Branch.

--- EXHIBIT NO. 11A ---

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The Commission is requested to consider

The Science of Medicine

(c) rethink the nature of man and his status in a technological culture. "THE NATURE OF MAN in Theological and Psychological Perspective" is just off the press. It is edited by Simon LeGoff and includes contributions from such

Walter Alexander and several others. This book will be a thorough study and is available from



HARPER & BROTHERS, PUBLISHERS, NEW YORK.

(b) consider seriously the findings of the fourth symposium of the Academy of Religion and Mental Health, November 18-20, 1960 on "THE PLACE OF VALUE SYSTEMS IN MEDICAL EDUCATION". The report is available from the ACADEMY OF RELIGION AND MENTAL HEALTH, 16 East 34th STREET, NEW YORK 16, NEW YORK.

II. The Federal Government make grants available to the provinces for the provision of chaplaincy services in the large hospital centers under Chapter 28 (1957) of the Hospital Insurance and Diagnostic Services Act.

III. The Federal Government make scholarships and bursaries available for graduate studies in the hospital chaplaincy, that trained and experienced chaplains be qualified to take their place as members of the healing team and to participate as teachers in the programs of medical and theological education.

THE CHAIRMAN: Now we have the submission of the College of Physicians and Surgeons, Province of Alberta; the Canadian Medical Association, Alberta Division; Faculty of Medicine, University of Alberta.

SUBMISSION OF

THE COLLEGE OF PHYSICIANS AND SURGEONS
Province of Alberta

CANADIAN MEDICAL ASSOCIATION
Alberta Division

FACULTY OF MEDICINE
University of Alberta



1 APPEARANCES:

2 DR. R. K. C. THOMSON

3 DR. L. C. GRISDALE

4 DR. D. F. McPHERSON

5 DR. R. WOOLSTENCROFT

6 DR. W. BRAMLEY-MOORE

7 DR. J. S. THOMPSON, Assistant Dean,
8 Faculty of Medicine,

9 DR. D. R. WILSON, Professor of Medicine.

10 DR. S. GREENHILL, Professor of Preventive
11 Medicine.

12 DR. A. A. DIXON, President, Canadian
13 Medical Association,
14 Alberta Division,

15 DR. M. M. SEREDA, President,
16 College of Physicians &
17 Surgeons of Alberta.

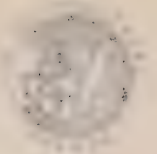
18 THE CHAIRMAN: Dr. Thomson, are you
19 the spokesman?

20 DR. THOMSON: Yes, Mr. Chairman. I
21 would like to have you know that our dean, Dr. Walter
22 MacKenzie would have me give you his regrets at not being
23 here but his duties have taken him to Africa.

24 If I may proceed with the summary and
25 recommendations. You will probably have noticed in the
26 body of the brief that medical education is a continuing
27 process that goes on into the years of post-graduate as
28 well as the under-graduate area, and our first comment
29 would have to do with that.

30 SUMMARY AND RECOMMENDATIONS

1. The preparation of this brief as a joint
presentation has brought to us more clearly the many



1 APPENDICES:

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DR. R. WOOLSTON

DR. W. SPANLEY-MOORE

Faculty of Medicine,

Professor of Medicine.

Professor of Preventive
Medicine.

President, Canadian
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President,
College of Physicians &
Surgeons of Alberta.

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DR. S. GARMERHILL

DR. A. A. DIXON

DR. M. H. SETHNA

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well as the under-graduate years, and our first comment
would have to do with that.

SUMMARY AND RECOMMENDATIONS

1. The preparation of this brief as a joint
presentation has brought to us more clearly the many



1 facets of health services. We feel that while the health
2 services available to the citizens of our province are
3 generally good our examination has revealed some areas of
4 defect or need.

5 2. We realize that Canada's future medical
6 needs will be different in kind and number from those of
7 today. As a result we have tried to present methods of
8 broadening the learning experience of medical under-
9 graduates, graduates and practicing physicians, and to
10 picture the role and function of the hospital as it is
11 changing in response to newer patterns of disease and
12 methods of practice.

13 3. While we have stressed the importance of
14 medical education there has been no attempt to gloss over
15 the problems connected with attracting future medical
16 and para medical personnel, or with the expansion of
17 physical facilities necessary for providing health services.

18 4. Our recommendations are directed toward
19 ".....ensuring that the best possible health services be
20 available to all Canadians". We relate them to our
21 proposed priorities in the development of health services
22 but wish to stress the interdependence of many methods of
23 improving these services. This means that often a
24 number of recommendations must be implemented concurrently
25 and this is particularly true with regard to personnel and
26 facilities. It is our belief, however, that in the
27 provision of health services for prevention, diagnosis,
28 treatment and rehabilitation the physician is the central
29 factor. With these considerations in mind we make the
30 following recommendations.



5. Recommendation 1

Recruitment and Training of Health Personnel

In order to serve the needs of the people of Alberta we must be graduating 120 medical students per annum by 1980. Our first recommendation therefore concerns itself with ensuring that the necessary number of applicants is obtained in each year, and that their medical education is secured so that the final product can best serve the people of Canada.

(a) Aggressive recruitment programmes are essential and with them financial aid to students in the form of scholarships and loan funds should be established.

(b) The increase of student enrollment will necessitate not only additional teaching staff but also an increase in the salary levels of medical graduates working in the basic science departments. Additions will be required to the basic science and clinical departments of the school to provide adequate teaching, research, office and library space, and equipment.

(c) To ensure that the best education of the student obtains, the head of any clinical department of the medical school must also be the director of the equivalent clinical department in the main teaching hospital, and he should have the authority to recommend and appoint all clinical teachers in the other teaching hospitals. Further, the junior internship should be the responsibility of the medical school, and should be spent only in those hospitals directly affiliated with the school. The physician, the graduate student and the



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1 undergraduate student all form part of the treatment team
2 for medical care and education, and legislation must
3 ensure that this treatment team approach is not destroyed.

4 (d) From the point of view of medical
5 education the advanced graduate student is an indispensable
6 addition to the personnel of any teaching hospital and his
7 importance should be reflected by adequate remuneration.
8 Not only through the undergraduate and graduate training
9 years but on into the years of practice there must be
10 education of the physician if he is to bring the best care
11 to his patients. This end can be served by the appoint-
12 ment of a Director of Continuing Medical Education within
13 the medical school. It is considered that the cost of
14 continuing education in the form of refresher courses for
15 practicing physicians should be an allowable income tax
16 deduction.

17 (e) Medical Research is an integral part
18 of education and is fundamental to the improvement of
19 health services. To maintain its value, research grants
20 should be granted to proven research workers on a long-
21 term basis and should be increased by 30% to provide a
22 realistic basis for salaries.

23 (f) Paramedical personnel must be
24 recruited and trained at the same time as medical per-
25 sonnel if efficient health services are to be available.
26 In certain instances where no training facilities exist
27 the establishment of schools is necessary. In the case
28 of social workers a school should be established at the
29 University of Alberta, while in the case of speech
30 therapists or of orthotists -- these are commonly known



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1 as brace makers or prosthetists but orthotists is the
2 correct word -- one school in Canada would appear to be
3 sufficient.

4 6. Recommendation 2

5 The Provision of Facilities in Teaching
6 Hospitals

7 (a) Consideration must be given to the
8 special requirements of teaching hospitals. It is in
9 these hospitals that teaching, research and advanced in-
10 vestigation related to patient care create larger operat-
11 ing costs. These additional costs should be recognized
12 as part of the annual budget.

13 (b) Expansion and improvement in the Out
14 Patient Department of our main teaching hospital is
15 necessary. The development of day care units would help
16 to relieve some of the demand for acute treatment beds,
17 and at the same time would provide teaching and patient
18 training facilities. In these same teaching hospitals,
19 social service departments should be developed to
20 facilitate the most advantageous relocation of the patient
21 as soon as active treatment is completed.

22 7. Recommendation 3

23 The provision of Hospital Facilities

24 (a) We have indicated that active
25 treatment beds are deficient in number in the City of
26 Calgary (Paragraphs 147, 308) and this deficiency is
27 interfering with the provision of best health care. We
28 recommend that a new 700 bed active treatment hospital be
29 built in Calgary (Paragraph 309). This is in addition
30 to the Provincial Foothills Hospital proposed for Calgary.



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(a) Consideration must be given to the special requirements of teaching hospitals. It is in these hospitals that teaching, research and advanced investigation related to patient care create larger operating costs. These additional costs should be recognized as part of the annual budget.

(b) Expansion and improvement in the Out Patient Department of our main teaching hospital is necessary. The development of day care units would help to relieve some of the demand for acute treatment beds, and at the same time would provide teaching and patient training facilities. In these same teaching hospitals, social service departments should be developed to facilitate the most advantageous relocation of the patient as soon as active treatment is completed.

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1 (b) The auxiliary hospital programme
2 (Paragraphs 151 - 152, 311 - 312) which is designed to
3 accommodate some rehabilitatable patients and some
4 continuing care patients should relieve the congestion
5 caused by these patients remaining in acute treatment
6 hospitals. We believe however that unless this programme
7 is expanded by 400 beds that the relief of congestion will
8 not occur.

9 (c) To maintain the flow of patients from
10 the active treatment hospitals to convalescent or
11 auxiliary hospitals, we recommend that special consider-
12 ation be given to providing special supervised domiciliary
13 accommodation for senile non-psychotic patients
14 (Paragraphs 155, 217 - 218). These patients often occupy
15 beds in auxiliary hospitals which are not suited to their
16 care and prevent the utilization of those beds by those
17 who need them.

18 (d) An adjunct to both acute and
19 convalescent hospitals is the home care programme
20 (Paragraphs 160, 215). We believe that study of, and
21 possibly implementation of, such a programme is necessary.

22 (e) Promoting the rehabilitation of
23 patients necessitates the establishment of units for this
24 purpose in all hospitals of over 350 beds, and basic
25 equipment in all hospitals of 100 to 350 bed size
26 (Paragraphs 68 - 74, 319 - 320).

27 8. Recommendation 4

28 Expansion of Mental Health Services

29 We have outlined the need for psychiatrists
30 and paramedical personnel (Paragraphs 87 - 93) in the



(Paragraphs 151 - 152, 311 - 312) which is designed to accommodate some rehabilitable patients and some caused by these patients remaining in acute treatment hospitals. We believe however that unless this programme is expanded by 400 beds that the relief of congestion will not occur.

(c) To maintain the flow of patients from the active treatment hospitals to convalescent or auxiliary hospitals, we recommend that special consideration be given to providing special supervised domiciliary accommodation for senile non-psychotic patients (Paragraphs 155, 317 - 318). These patients often occupy beds in auxiliary hospitals which are not suited to their care and prevent the utilization of those beds by those who need them.

(d) An adjunct to both acute and convalescent hospitals is the home care programme. Possibly implementation of such a programme is necessary.

(e) Promoting the rehabilitation of patients necessitates the establishment of units for this purpose in all hospitals of over 350 beds, and basic equipment in all hospitals of 100 to 350 bed size (Paragraphs 68 - 74, 319 - 320).

8. Recommendation 4

Expansion of Mental Health Services
We have outlined the need for psychiatric and paramedical personnel (Paragraphs 87 - 93) in the



1 field of mental health, but along with these needs there
2 is a requirement for change and improvement in physical
3 facilities (Paragraphs 313 - 318). The expansion of
4 these facilities is recommended as a progressive staged
5 programme, beginning with the establishment of psychiatric
6 units in general hospitals and extending to the decentral-
7 ization of our two major mental hospitals and the
8 establishment of regional 400 bed psychiatric hospitals.

9 9. Recommendation 5

10 Universally Available Voluntary Medical
11 Insurance.

12 We have stated our belief that comprehen-
13 sive medical services insurance should be available to
14 all citizens (Paragraphs 55 - 64). We recommend that
15 those who can afford to pay should assume the responsi-
16 bility for the costs of their medical services or medical
17 services insurance (Paragraph 193); those who qualify
18 for social assistance should have their medical insurance
19 paid for by the Provincial Government ~~with subsidy by the~~
20 profession (Paragraph 194); those who fall between
21 these groups should be subsidized by the Provincial
22 Government to help them pay the costs of their medical
23 services insurance (Paragraph 202).

24 10. Recommendation 6

25 Drug Costs

26 (a) To alleviate hardships which may
27 be created by the cost of drugs we recommend that the
28 sales tax on drugs provided by prescription under the
29 Regulations of the Food and Drug Act be removed
30 (Paragraph 212).



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We have stated our belief that comprehen-
sive medical services insurance should be available to
all citizens (Paragraphs 25 - 28). We recommend that
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bility for the costs of their medical services or medical
services insurance (Paragraph 103); those who qualify
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These groups should be subsidised by the Provincial
Government to help them pay the costs of their medical
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10. Recommendation 6

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(a) To alleviate hardships which may
be created by the cost of drugs we recommend that the
sales tax on drugs provided by prescription under the
Regulations of the Food and Drug Act be removed



(b) For those citizens requiring certain expensive life saving and/or long term health maintaining drugs we recommend that assistance be given under a means test (Paragraphs 189, 213).

11. Recommendation 7

Miscellaneous Improvements

It is recommended that

(a) the cancer services in our province should be placed under an Alberta Cancer Foundation (Paragraphs 123, 211),

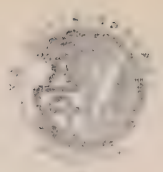
(b) the Federal Government, through the Department of Indian Affairs and Northern Health Services, (Paragraphs 107, 205) should increase its existing health education measures especially regarding infant feeding and nursing care of sick children,

(c) the Federal Government should encourage specially selected suitable Indian students to take advantage of the existing educational and financial facilities to enable them to take training in all aspects of health care, medical and paramedical (Paragraph 206).

(d) governments, at all levels, should carry out educational campaigns stressing the benefits of fluoridation of communal water supplies (Paragraph 210).

(e) any coverage of laboratory and radiological out-patient services should be by insurance under the widely accepted plans such as Medical Services (Alberta) Incorporated and should be provided not only at hospitals but at properly equipped and medically supervised private facilities.

Thank you, sir.



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supervised private facilities.

Thank you, sir.



1 THE CHAIRMAN: Thank you, Dr. Thomson.

2 DR. THOMSON: Mr. Chairman, we would
3 like to enter as an exhibit, three copies of a study of
4 pre-paid medical care coverage. These have been made
5 available to your Commission. If our brief is 115, I
6 would like to present as 115A a study of pre-paid medical
7 coverage in Alberta, report No. 1.

8 THE CHAIRMAN: Exhibit 115A.

9
10 --- EXHIBIT NO. 115A: A Study of pre-paid
11 medical coverage in
12 Alberta. Report No. 1
13 tabular results to
14 Form A conducted for
15 The Canadian Medical
16 Association, Alberta
17 Division.

18 DR. THOMSON: And next, is a study of
19 pre-paid medical coverage in Alberta, Report No. 2, 115B,
20 and thirdly, a study of pre-paid medical coverage in
21 Alberta, Report No. 3B, Summary and Analysis.

22 --- EXHIBIT NO. 115B: A study of pre-paid
23 medical coverage in
24 Alberta, Report 2.
25 Tabular results to
26 Form B conducted for
27 the Canadian Medical
28 Association, Alberta
29 Division.

30 --- EXHIBIT NO. 115C: A study of pre-paid
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1 THE CHAIRMAN: Thank you, Dr. Thomson.
2 These reports which you have just filed will be of value
3 to our research staff.

4 Now, is there anyone else with your delega-
5 tion, with your group here, that wishes to add anything
6 to what you have said before we proceed to a general
7 discussion?

8 DR. THOMSON: I don't think so, sir,
9 but they are all prepared to answer any questions which
10 you might like to put to them.

11 THE CHAIRMAN: Dr. Thomson, I want
12 to raise a matter which we haven't discussed at prior
13 hearings, and that is the relationship of the College of
14 Medicine to the Medical Association in Alberta.

15 I understand it is the Alberta branch
16 of the Canadian Medical Association, and here in Alberta
17 you have a third partner in this submission, the Faculty
18 of Medicine. For the moment, I want to discuss the
19 relationship of the College and your Association.

20 DR. THOMSON: In Alberta, Mr. Chairman,
21 could I refer this question to the registrar of the
22 College, Dr. Bramley-Moore.

23 THE CHAIRMAN: As I understand, the
24 College of Medicine is a body created by the Legislature
25 of the Province of Alberta, the College of Physicians
26 and Surgeons. It is created by statute and has certain
27 functions as defined by statute. In that situation does
28 the medical profession recognize or look upon the College
29 as an agency of government?

30 DR. BRAMLEY-MOORE: To a certain



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DR. RAMSEY-MOORE: To a certain



1 degree, yes. They recognize that the government does
2 have to have an agency either within or without itself
3 to provide the licensing and disciplining of the
4 profession within the province, and recognizing that the
5 College is -- that responsibility was given by government
6 and the profession does recognize it as an agency of the
7 government.

8 THE CHAIRMAN: And carrying out
9 functions the government might otherwise carry out through
10 some other agency?

11 DR. BRAMLEY-MOORE: Through some other
12 agency.

13 THE CHAIRMAN: If the College of
14 Physicians and Surgeons did not exist?

15 DR. BRAMLEY-MOORE: That is correct.

16 THE CHAIRMAN: Then we come to the
17 Association; how would you describe it, the functions of
18 the Association?

19 DR. BRAMLEY-MOORE: I think, sir, to
20 some extent the functions of the Association were outlined
21 in the brief. The Association being a voluntary organ-
22 ization is concerned with the objectives outlined in the
23 brief, the promotion of health and prevention of disease
24 in the province, the improvement of medical services,
25 the maintenance of integrity and honour in the profession
26 in the province, and in the performance of all other
27 matters which are in the interest of the people and of
28 the profession in the development of health care.

29 The College of Physicians and Surgeons
30 under its Act, as outlined, is responsible for the



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 the profession in the development of health care.
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 under its Act, as outlined, is responsible for the



1 maintenance of standards of care within the province,
2 so there is a very definite overlap of responsibility
3 given to the College by the government as well as with
4 that of the voluntary organization.

5 THE CHAIRMAN: Have you that section
6 there, from which you have just made that statement?

7 DR. BRAMLEY-MOORE: I am sorry, I
8 haven't got a copy of the Medical Profession Act with me.
9 Dr. Grisdale has.

10 I might state that the relationship
11 between the two organizations came about primarily at the
12 request of government bodies relating back to 1919 and
13 1920 when the Workmen's Compensation Board was established.
14 The Compensation Board initially began to discuss matters
15 with the Alberta Medical Association as it was then known.
16 However, since the Medical Association was a voluntary
17 organization and didn't have all the doctors of the
18 province as its members, the Workmen's Compensation Board
19 indicated that it would desire to talk to an organization
20 which might represent all the profession, and stated it
21 wished to talk to the College in matters relating to the
22 Compensation Board. At that time, the relationship
23 developed between the two bodies.

24 THE CHAIRMAN: The problem that may
25 arise is, do you sense any possibility of a conflict
26 between the Association and the College?

27 DR. BRAMLEY-MOORE: No, sir. They
28 are both interested in the welfare of the public. They
29 are both interested in the welfare of the profession.
30 The interests of the profession and the interests of the



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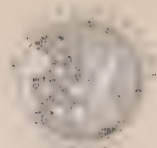
1 public basically are the same, and I can see no reason
2 for a conflict between the two organizations.

3 THE CHAIRMAN: We are putting this
4 question to you in Alberta because we know there is no
5 conflict. We are aware there is no conflict between your
6 Association and the government, but assuming that such
7 a situation could exist, of a conflict between the
8 Association and the government, does the tying together
9 of the College and the Association present any difficulties
10 if such a situation arose?

11 DR. BRAMLEY-MOORE: I don't think
12 so, sir. The Association has its own director, and should
13 the government see fit to remove the powers of
14 the College, to take over on to itself, the Association
15 would be quite capable of carrying on.

16 THE CHAIRMAN: Well, we accept that
17 the College is an agency of the government, can the
18 College become an instrument of government policy that
19 may be at variance with the policy of the Association?

20 DR. BRAMLEY-MOORE: I don't believe,
21 sir, that it is apt to. Of course, that is a matter of
22 opinion. The initial basic responsibility we pointed
23 out is of licensing and discipline and those being the
24 two primary functions, it is only in those points that
25 the government is apt to interfere with the College.
26 The government is, as you will note going through the
27 brief, does recognize the College in many areas as its
28 advisory body, in the areas of Highway Department,
29 Traffic Accident, particularly, in the Department of
30 Agriculture, Veterinary Service, almost every one of the



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1 departments that deal with health, the government refers
2 to the College for advice.

3 THE CHAIRMAN: As I say, we put this
4 question, not on the basis of any existing or even
5 expected situation in Alberta, or anywhere else, but
6 because the government has this control over the College,
7 do you sense any possibility of the government disciplin-
8 ing the profession through the College, that is,
9 controlling the profession?

10 DR. BRAMLEY-MOORE: Where there is
11 a relationship, whether in Alberta or not, the government
12 in any province can exert some control over the
13 profession through the licensing authority of the
14 profession in that province. In other words, I create
15 a situation -- we will say that the government has
16 decided to introduce a compulsory state medical programme
17 and the profession has indicated they will not co-
18 operate. I think such a situation may exist. Then the
19 government may state we will -- any person getting a
20 licence in this province must do certain things. That
21 situation could exist in any province. It is not any
22 different.

23 THE CHAIRMAN: Is it more likely to
24 exist in a province where the College and the Association
25 are occupying the same bed?

26 DR. BRAMLEY-MOORE: No, sir. It is
27 not more likely to happen in that province. It could
28 happen, as I say, it could happen in any province. The
29 Medical Association in itself, if the government decided
30 to licence people, and they had to be licensed with the



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1 licensing authority to practice in that province, then
2 the medical profession in that province would disappear
3 because they wouldn't be licensed to practice there.

4 THE CHAIRMAN: In any event, you
5 don't think there is any possibility?

6 DR. BRAMLEY-MOORE: No, sir. I would
7 also say, sir, that we feel that all organizations are
8 so set-up that should one of those dangers arise that
9 the Association is capable of carrying on.

10 THE CHAIRMAN: You appreciate the
11 Association becomes the political arm of the profession?

12 DR. BRAMLEY-MOORE: That is right,
13 sir.

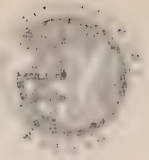
14 THE CHAIRMAN: And the political arm
15 of the Association dealing with the political power of
16 the province, which is the government, do you think that
17 there is any, that we need not concern ourselves with
18 the fact that the Association and the College virtually
19 travel together?

20 DR. BRAMLEY-MOORE: No, sir.

21 COMMISSIONER McCUTCHEON: What the
22 registrar said, he felt the organizations could put a
23 divorce into effect very quickly.

24 DR. BRAMLEY-MOORE: That is correct,
25 sir. As you note we have the presidents of the two
26 organizations here, and if one would disappear, then the
27 other would continue to exist.

28 THE CHAIRMAN: Now, in the matter of
29 the furnishing of medical services, to what extent is
30 group practice carried on in rural Alberta?



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THE CHAIRMAN: Now, in the matter of

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1 DR. THOMSON: Sir, there has been
2 an increase in group practice in Alberta over the last
3 number of years.

4 THE CHAIRMAN: In rural Alberta.
5 The matter of group practice in the city is a very simple
6 thing.

7 DR. THOMSON: I realize that, sir.
8 While I cannot give you specific figures, it has been
9 shown in the rural areas, the smaller communities, there
10 is a tendency towards the group practice.

11 THE CHAIRMAN: How does it work out?
12 What are the mechanics of it in the rural areas? Is it
13 just a matter of two or three doctors getting together?

14 DR. THOMSON: Yes, sir. In quite a
15 number of our Alberta smaller towns, the doctors ---
16 two, three, four or five, or so, in a number -- practice
17 as a group.

18 Now, the actual arrangements between
19 them varies somewhat from town to town. But, in general,
20 we would say they practice as a group. We would feel
21 that in those communities they are providing an excellent
22 type of service.

23 THE CHAIRMAN: Are you familiar with
24 the type of group practice which there is some volume of
25 in rural New York?

26 DR. THOMSON: Yes, known as H.I.P.

27 THE CHAIRMAN: Yes, that is part, but
28 particularly there is a well known one in Rip Van Winkle
29 County. Are you familiar with that one?

30 DR. W. BRAMLEY-MOORE: I am not, sir.



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DR. W. BRAMLEY-MOORE: I am not, sir.



1 THE CHAIRMAN: Dr. Thomson, you say
2 you are?

3 DR. THOMSON: I know something of it,
4 sir, yes.

5 THE CHAIRMAN: Have you anything of
6 that nature here, which is a central point -- doctors
7 living in various smaller communities operating out of
8 a central location where they have x-ray facilities and
9 all the specialized facilities?

10 DR. BRAMLEY-MOORE: There are, sir,
11 two communities in Alberta where something of that type
12 exists. One community to the north-west of Edmonton,
13 the doctors in the two towns, one with the hospital and
14 one without, form a group. There are resident doctors
15 in both towns. In the southern part of the province of
16 Alberta, there is a community where the groups of doctors
17 in the town with the hospital do carry on practice in
18 neighbouring towns, which are without hospitals, but they
19 are not resident doctors in the town -- in the adjoining
20 towns.

21 THE CHAIRMAN: Has any study been
22 made in terms of rural group practice by your Association
23 in Alberta?

24 DR. BRAMLEY-MOORE: No, sir.

25 DR. THOMSON: No such one has been
26 made.

27 THE CHAIRMAN: Because, accepting
28 your statement of having the best medical service avail-
29 able to most people, it becomes not a difficult matter
30 in a settled community, in a city, and in the more



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1 populous areas, but how do you propose to do that in the
2 sparsely populated and isolated areas?

3 DR. THOMSON: Well, Mr. Chairman,
4 there are one or two areas in Alberta where the popula-
5 tion density might warrant a resident physician and where
6 there is not one at the present time.

7 These areas are very, very few. There
8 have been changes in the pattern of practice, it is true,
9 where the doctors tend to locate in the towns, in the
10 smaller urban areas; and from the point of view they
11 have hospital facilities, from the point of view that in
12 those areas they can set up groups, and from the point of
13 view in those areas, as you have mentioned, in other
14 places they might then be able to have facilities.

15 The improvement in roads has met the
16 need and the concept of the doctor out in the bush, as
17 it used to be known, out in the country, is not a great
18 necessity.

19 Now, there are one or two areas and we
20 are constantly working towards trying to see that those
21 areas are filled, but they are very short in number in
22 Alberta. The newer patterns of practice and the facili-
23 ties and the means of communication and conveyance to
24 and from have radically changed, I think, that system of
25 country practice.

26 THE CHAIRMAN: Now, Dr. Thomson,
27 yesterday Dr. Ross, the Minister of Health, expressed
28 the view that the government of Alberta saw some value
29 in a deterrent charge as applied initially now to
30 hospitalization, but he could conceive it as being of



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yesterday Dr. Ross, the Minister of Health, expressed
the view that the Government of Alberta saw some value
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1 value in a physicians service plan.

2 What is the view -- are you in a
3 position to give the view of your Association on this
4 question of a deterrent or a utilization fee, or of
5 whatever you want to call it?

6 DR. THOMSON: Yes, Mr. Chairman.
7 The profession in Alberta are interested in comprehensive
8 care for the people and they would like in that compre-
9 hensive care to have no deterrents or no exclusions.
10 It is true that under a voluntary system the deterrent
11 may be something which prevents the patient from going
12 to the doctor, and the profession do not feel that this
13 is reasonable.

14 Now, much study has been given to it.
15 It is our view that the deterrents under our voluntary
16 system are not a reasonable approach to it. As far as
17 the hospital is concerned, we look on that as co-
18 insurance and not necessarily as a deterrent. It
19 probably does not act in that manner to any great extent.
20 I am speaking, sir, of our present system, under our
21 voluntary system of private physicians services, and we
22 do not feel that under our plan of pre-payment that
23 deterrents are in the best interests of the patient.

24 THE CHAIRMAN: Has your Association
25 found or has it experienced over the past four years
26 since the hospitalization plan has been in effect --
27 three years and some months -- that the so-called
28 deterrent or \$2.00 a day charge has kept anyone out of
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Dr. THOMSON: It has not been our



1 experience, sir. The present system with the \$2.00 a
2 day co-insurance is very little different from the
3 programme which existed before the federal-provincial
4 agreement, the Hospitalization Diagnostic Insurance Act.

5 THE CHAIRMAN: So it was not the
6 initiating of a new programme in Alberta?

7 DR. THOMSON: It was not a new
8 programme, no, sir, and we have not been aware of the
9 \$2.00 co-insurance factor acting as a deterrent.

10 THE CHAIRMAN: Well now, you are
11 familiar, I take it, with the situation in a health unit
12 such as Swift Current?

13 DR. THOMSON: Yes, sir.

14 THE CHAIRMAN: That is on the eastern
15 border, where the patient makes a contribution to the
16 physicians services for the first visit or for home
17 visits, and that kind of thing?

18 DR. THOMSON: Yes, sir.

19 THE CHAIRMAN: Now, you say you would
20 not want that or, your Association would not want that
21 kind of procedure in Alberta?

22 DR. THOMSON: It has been the opinion
23 of our Association that we have not developed -- we have
24 not found a great need for it, and we have felt it is
25 probably not in the best interests of the people.

26 We wonder, sir, if we might direct
27 this question to Dr. Grisdale or Dr. McPherson, who are
28 both intimately associated with this problem. Dr.
29 McPherson?

30 DR. McPHERSON: Mr. Chairman, we feel



experience, sir. The present system with the \$2.00 a

day co-insurance is very little different from the

programme which existed before the federal-provincial

agreement, the Hospitalization Diagnostic Insurance Act.

THE CHAIRMAN: So it was not the

initiating of a new programme in Alberta?

DR. THOMSON: It was not a new

programme, no, sir, and we have not been aware of the

\$2.00 co-insurance factor acting as a deterrent.

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familiar, I take it, with the situation in a health unit

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DR. McPHERSON: Mr. Chairman, we feel



1 from the studies that have been available to us that the
2 co-insurance factor does not really -- if you approach
3 it over an adequate period of time -- produce any deterrents
4 as far as the level of service that your population is
5 going to require. I think, Mr. Chairman, that could be
6 applied fairly reasonably to the Swift Current experience;
7 that initially with the introduction of deterrent fees,
8 there was a levelling down of service demands, but within
9 a matter of a two year period ----

10 THE CHAIRMAN: You are referring to
11 the 1953 period?

12 DR. McPHERSON: Yes, the level of
13 service approached the figures which had previously
14 existed.

15 THE CHAIRMAN: I just mentioned that
16 because the charts that we saw recently would not appear
17 to bear that out. You have the graph coming down in 1953,
18 then levelling off, but not going back up.

19 DR. McPHERSON: I believe that
20 initially when those deterrents were first projected that
21 there was a levelling off, as you suggest.

22 THE CHAIRMAN: But I must say that
23 the suggestion of the levelling off is not attributed
24 to the deterrent fee, but certain other procedures of
25 self-discipline amongst the doctors?

26 DR. McPHERSON: That is correct.
27 Another thing, with reference to deterrent fees, often
28 times something happens that we feel is a pernicious
29 thing both as far as the doctor is concerned and the
30 patient. And, again, if you will permit me to refer to



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patients. And, again, if you will permit me to refer to



1 the situation in Saskatchewan where the Saskatchewan
2 Health Doctor Sponsored Plan introduced a co-insurance
3 feature, they found that in the rural areas, particularly,
4 that the doctor was accepting what the plan paid but he
5 was not extra-billing his patient for the amount of the
6 deterrent, so that it ceased to function as a deterrent
7 as far as the patient was concerned, and the doctor was
8 in the obviously poor position of rendering a service for
9 considerably less than the established level of fees.

10 We also found sometimes that when these
11 deterrents are applied particularly from service to first
12 visits that often times the doctor, in deference to his
13 patient, and again, I think this is more applicable in
14 the rural areas, where there is a more personal relation-
15 ship, often, between doctor and the patient, that he
16 tends to sort of write off that first visit or deterrent
17 fee. So, he is subsidizing and absorbing personally a great
18 share of the cost which, presumably, is being saved in
19 this deterrent mechanism.

20 I do not feel, and I think we do not
21 feel as a profession that this is conducive to the best
22 interests either of the patient or of the doctor render-
23 ing that service.

24 DR. GRISDALE: I think the only other
25 point that we have thought of when we discussed this
26 previously is that a deterrent of \$1.00 is expensive to
27 collect, for what you collect. It costs a fair amount
28 to send out a couple of bills to collect a dollar, and it
29 is just not practical, if that is all the deterrent
30 amounts to.



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is just not practical, if that is all the deterrent
amounts to.



1 DR. THOMSON: I believe one should
2 look at the word "deterrent" and the terminology.

3 Basically, it indicates that this is something which is
4 applied to deter or to prevent someone from using --

5 THE CHAIRMAN: From over-utilization, is
6 the way it is put.

7 DR. THOMSON: From over-utilization,
8 and we become faced with the fact that what is over-
9 utilization. If the patient says he is sick and he wants
10 to come the first or second or third time, do we feel he
11 is over-utilizing, and should he be responsible?

12 We like to feel in the voluntary system,
13 where they are responsible in part, at least, for the
14 burden of cost that they are then sharing with us; that
15 they are not going to over-utilize in that sense; that
16 we would not want to deter them from getting attention.

17 This is not necessarily so in some of
18 the plans which appear to be free, such as the state-
19 controlled plan where the individual does not have that
20 feeling and sense of responsibility, and therefore, they
21 utilize it to a larger degree. But, in the voluntary
22 plan, sir, we have not found a need nor a desire for
23 introducing deterrents in Alberta.

24 THE CHAIRMAN: Supposing you had a
25 compulsory plan?

26 DR. THOMSON: I am sorry, sir, I do
27 not know what my attitude towards that would be if you
28 said if we had a compulsory plan. I believe that this
29 would necessitate a very careful review of the whole
30 situation in the light of a new terms of reference, you



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would necessitate a very careful review of the whole

situation in the light of a new terms of reference, you



1 might say.

2 THE CHAIRMAN: Well now, you say --
3 and, again, I am only paraphrasing -- the service should
4 be available to everybody regardless of ability to pay?

5 DR. THOMSON: That is correct.

6 THE CHAIRMAN: And you use the
7 expression "means test".

8 DR. THOMSON: Yes, sir.

9 THE CHAIRMAN: What is the view of
10 your Association? What do you mean by a means test and
11 how would it be applied, or what is the machinery by which
12 a means test would be put into operation?

13 DR. THOMSON: Well, sir, the means
14 test is a method of determining need, let us say. It has
15 been applied by governments at all levels for some time,
16 both municipal, provincial and to a degree, I suppose,
17 in the federal level in the terms of our income tax.

18 There has been for a long time some
19 concern that a means test was something which was nasty,
20 something that brought with it ignominy and stigma, and
21 people were dis-inclined to have anything to do with a
22 means test because of these various features.

23 One recognizes that there is no desire
24 on the part of anyone to be dependent upon other people
25 for assistance. But while this was not clear, it was a
26 general concept that this was not an acceptable thing.
27 During the course of the Alberta survey, which has been
28 referred to in your scientific research division ---

29 THE CHAIRMAN: Yes?

30 DR. THOMSON: We found that on this

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referred to in your scientific research division --

THE CHAIRMAN: Yes?

DR. THOMSON: We found that on this



1 survey when we put this question to the people who did not
2 have any coverage, and therefore, people who might likely
3 be unbiased so far as the need was concerned, seventy-six
4 per cent of them said they were in favour of a means test.

5 THE CHAIRMAN: Those are the figures
6 you give on the top of page 48?

7 DR. THOMSON: Page 48, yes, sir.
8 A particularly interesting part, I think, to this was also
9 that of the thirteen per cent --

10 THE CHAIRMAN: Would you expand on
11 the nature of that survey?

12 DR. THOMSON: This, to some degree,
13 sir. I cannot go into all of the details of it because it
14 is an actuarial basis.

15 THE CHAIRMAN: No, in capsule form.

16 DR. THOMSON: The medical profession
17 set up a special committee to study pre-paid medical care
18 in 1960, and one of the things that they felt would be
19 necessary out of that would be to determine the attitude
20 of the people towards pre-payment insurance and in the
21 course of that to try to determine how many people were
22 covered and by what means.

23 This was taken on by a consulting firm
24 who are recognized as survey experts, and they surveyed
25 some two thousand households in the province of Alberta
26 which we are informed was a valid sampling, a valid survey.
27 In that survey, they sent individuals to all of the
28 households, these two thousand households in the various
29 districts, both urban and rural in Alberta, and then they
30 compiled their figures from that, sir.



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compiled their figures from that, sir.



1 THE CHAIRMAN: They were directing
2 their attention amongst other things in particular to
3 this question of a means test?

4 DR. THOMSON: This is one of the
5 attitudinal questions which were asked, sir. The actual
6 question, if we might refer to it, is available. It was:
7 "Suppose a plan were introduced in which
8 everyone was covered; most families paid
9 all of the monthly premiums, and those
10 who were unable to pay the premiums could
11 have that payment made by submitting to
12 a means test designed to prove ability to
13 pay. Would you approve or disapprove of
14 this means test?"

15 This was the type of question.

16 THE CHAIRMAN: Your answer was
17 seventy-six per cent were in favour of it?

18 DR. THOMSON: Yes, sir.

19 THE CHAIRMAN: Thirteen per cent not
20 in favour; and eleven per cent no opinion?

21 DR. THOMSON: No opinion, that is
22 right, sir.

23 The interesting part was that the
24 thirteen per cent, about fifty per cent of them were not
25 in favour of it because they felt it was a means of
26 chiseling on the part of undeserving individuals.

27 COMMISSIONER BALTZAN: This was done
28 by personal interviews?

29 DR. THOMSON: By personal interviews,
30 yes, Dr. Baltzan.



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DR. THOMSON: By personal interviews.



1 COMMISSIONER BALTZAN: Not by letter?

2 DR. THOMSON: Not by letter.

3 THE CHAIRMAN: Now, this question may
4 come in connection with another brief from the Medical
5 Services Group, but in the coverage under Medical Services is
6 there any income limitation, income ceiling in Alberta
7 beyond which the doctor may overbill?

8 DR. THOMSON: No, sir, not an income
9 limit.

10 THE CHAIRMAN: Is there any provision
11 for billing beyond what the physician gets from the plan?

12 DR. THOMSON: Yes, there is, sir.
13 According to the terms of the contract extra billing is
14 permitted by a specialist, not in the first instance, but
15 if service is continued. In other words, the patient is
16 referred by his doctor to a specialist and that consul-
17 tation is paid for. However, if the individual elects
18 to remain with that specialist then he may be extra-
19 billed, but he would be informed ahead of time that that
20 extra billing would be in order. Now, there are in the
21 field of obstetrics in particular practically all of
22 the specialists --- I say "practically" because I could
23 not be certain that we feel they all extra bill, but
24 these people go ahead and this obstetric service is
25 billed for over and above the amount allowed to the
26 general practitioner.

27 THE CHAIRMAN: Do you say that idea,
28 that principle of over-billing is a deficiency in the
29 providing of physicians services?

30 DR. THOMSON: I suppose it would



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THE CHAIRMAN: Do you say that then,

that principle of over billing is a deficiency in the
providing of physician services?
DR. THOMSON: I suppose it would



1 depend upon the philosophy of pre-payment.

2 THE CHAIRMAN: In a pre-payment plan,
3 of course?

4 DR. THOMSON: Yes, but to some extent
5 it is, I should suggest, in the manner in which the fee
6 schedule is set up that there is very little extra billing
7 in Alberta.

8 THE CHAIRMAN: Except in this one
9 field?

10 DR. THOMSON: That one field is the
11 particular one.

12 THE CHAIRMAN: That is a pretty big
13 one?

14 DR. THOMSON: That is one which the
15 people seem to like because the service is available and
16 these specialists have set this up. One is not at the
17 moment defending it except to indicate this is not very
18 frequently carried out and it would appear to be the most
19 equitable arrangement which can be made at this time.

20 THE CHAIRMAN: Dr. Thomson, with
21 X-millions of dollars available in Alberta has your
22 Association any definite views on what services should
23 have priority? Now, I mean to say, is it physician
24 services or what is the greatest need in Alberta today?

25 DR. THOMSON: I think we can answer
26 that fairly directly as we have attempted to do in our
27 list of priorities. Insofar as we have projected the need
28 for physicians in future, we must keep the house in order,
29 as it were, to promote that supply and see that efforts
30 directed to ensuring that are probably first.



1 THE CHAIRMAN: That is providing of
2 the personnel?

3 DR. THOMSON: That is number one.

4 THE CHAIRMAN: And I take it that
5 would be the view of the medical educators?

6 DR. THOMSON: This I will refer to
7 Dr. Thompson.

8 DR. THOMPSON: That is quite right.
9 We feel that is the main point in assistance at the present
10 time.

11 THE CHAIRMAN: Is it the providing or
12 do you go further and say that physician services to the
13 public is number one?

14 DR. THOMPSON: I do not think the
15 physician service to the public would be possible unless
16 provision is there and in providing the service to the
17 public we feel that the providing of the physician, the
18 body of the physician, is the main thing.

19 THE CHAIRMAN: What is the next?

20 DR. THOMPSON: I believe the area of
21 the facilities for the care of the patients.

22 THE CHAIRMAN: The buildings?

23 DR. THOMPSON: The buildings? This
24 might be, in certain areas, a continuing care. Whether
25 this is to be in the so-called convalescent or auxiliary
26 hospital programme or in the field of mental health, this
27 would appear to have high priority.

28 THE CHAIRMAN: May we now assume that
29 you have a reasonably adequate number of physicians and
30 suitably distributed and reasonably adequate physical



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1 plant; I think you would agree that is the situation in
2 Alberta today by and large?

3 DR. THOMPSON: I think it is, sir, yes.

4 THE CHAIRMAN: In that situation,
5 what is the greatest need in the matter of health services
6 in Alberta today?

7 DR. THOMPSON: The modification of
8 your improvement of the clinic facilities and the mental
9 health services.

10 THE CHAIRMAN: What is the situation
11 with regard to mental health services?

12 DR. THOMPSON: The reason for
13 suggesting the modification here arises out of the newer
14 concepts of the care of the mentally ill. There are
15 certainly bits and pieces for the people who are mentally
16 ill at the present time.

17 THE CHAIRMAN: These two large
18 institutions?

19 DR. THOMPSON: Two very large places
20 and a bare minimum of beds in the general hospitals. In
21 this regime according to the modern concept the recovery
22 rate while it is good is not as great, the impact on the
23 health of the individual emotionally and mentally is
24 probably not as good. There is still a lingering stigma,
25 a difference between mental illness and ordinary illness,
26 and one would hope that changes in facilities would be
27 such that a mentally ill patient would have the same
28 tone, regard and facilities as the ordinary or any other
29 illness. There should be no distinction. It is because
30 of this concept that we feel that this must be modified.



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29 home, regard and facilities as the ordinary or any other

30 illness. There should be no distinction. It is because

31 of this concept that we feel that this must be modified.



1 THE CHAIRMAN: Are you in a position
2 to give us any comparative figures for what is spent per
3 patient bed for the acutely ill in the general hospital
4 or in terms of mental hospitals?

5 DR. THOMPSON: I have not the accurate
6 figures here.

7 THE CHAIRMAN: Do any one of your
8 associates have that information?

9 DR. THOMPSON: No, sir, not at the
10 moment. These figures might be available from the
11 Department of Health very readily. We do know that there
12 is considerable difference. I am sorry I cannot quote
13 an accurate figure.

14 THE CHAIRMAN: We will get it from
15 a source that is able to give us the information accurately.

16 I see there is nothing here on tuber-
17 culosis; are you satisfied with the situation in regard
18 to governmental help in connection with tuberculosis?

19 DR. THOMPSON: Yes, sir. I believe
20 that the people are very well looked after in that regard
21 in the province. The provincial government maintains
22 its sanatoria at Edmonton and at Keith.

23 THE CHAIRMAN: Have you had the same
24 results here as elsewhere that the demand for beds in
25 sanatoria ---

26 DR. THOMPSON: It has gone down. In
27 some places in the northern area it has not gone down as
28 rapidly which is perhaps due to our Metis population plus
29 the newer people who have come into this area. One could
30 mention the Charles Cammel Hospital which looks after



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to give us any comparative figures for what is spent per patient bed in the country all in the general hospital

or in terms of mental hospitals?

DR. THOMPSON:

I have not the accurate

THE CHAIRMAN:

Do any one of your

associated have that information?

MR. THOMPSON:

No, sir, not at the

moment. These figures might be available from the

Department of Health very readily. We do know that there

is considerable difference. I am sorry I cannot quote

an accurate figure.

THE CHAIRMAN:

We will get it from

a source that is able to give us the information accurately

I see there is nothing here on number-

17, unless you are satisfied with the situation in regard

to Governmental help in connection with tuberculosis?

that the people are very well looked after in that regard

in the province. The provincial government is maintaining

the standards at London and at Kelowna.

THE CHAIRMAN:

Have you had the same

results here as elsewhere that the demand for beds in

hospitals is

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some places in the northern area it has not gone down as

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1 tuberculosis in the Indians and Eskimos. They are doing
2 a very creditable job in that area, but there is still
3 a much higher rate amongst these Indians and Eskimos than
4 it is in the other portions of the population. However,
5 I believe they are beginning to make headway.

6 THE CHAIRMAN: I will go down to
7 the reference on page 7 to cancer; what is involved in
8 your recommendation that cancer services should be placed
9 under an Alberta cancer foundation?

10 DR. THOMSON: I believe, sir, that
11 in the treatment or investigation and treatment of a
12 cancer there is a tremendous amount being done, and it
13 is hoped that this work can be co-ordinated or centralized
14 so that the maximum or optimum might be achieved. Now,
15 under a cancer treatment and diagnostic service which is
16 placed under the Department of Health it is extremely
17 unlikely that there would be any moneys coming from the
18 voluntary agencies who are so very, very interested in
19 this. Under the foundation it would be possible for
20 participation of the voluntary agencies and state to
21 produce the best in, not so much treatment as it is known
22 today, but in research and investigation in those areas.
23 This is a major implication behind suggesting that it be
24 under a foundation.

25 THE CHAIRMAN: You want to have
26 access to the voluntary contribution?

27 DR. THOMSON: Yes, sir, from the
28 voluntary agencies interested in the care, treatment and
29 rehabilitation of cancer.

30 THE CHAIRMAN: Would you apply that

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DR. THOMSON: Yes, sir, from the

voluntary agencies interested in the area, treatment and rehabilitation of cancer.



1 then to the other illness areas, arthritis and so forth,
2 the ten, twelve or fifteen organizations who are interested
3 in these specific illnesses?

4 DR. THOMSON: I believe each one
5 must be considered on its own merits. This does apply to
6 some degree in other areas but without upsetting the
7 balance certain ones might have application.
8 For instance, we have in Alberta the Alcoholism Foundation
9 and I believe it is an excellent method of handling this
10 situation; it certainly seems to work. So far as
11 arthritis is concerned, for instance, the Canadian
12 Arthritis and Rheumatism Society have a grant from the
13 government plus voluntary agencies and they carry on in
14 a field which is outside of the hospital and is again
15 referred to with a special title.

2 16 THE CHAIRMAN: Do you mean by this
17 recommendation that you would transfer control, the
18 operation of the free cancer clinics, that is, in
19 Edmonton, Calgary and Lethbridge from the Department to
20 the foundation?

21 DR. THOMSON: That would be the
22 implication, yes. I think the foundation would have to
23 have control of these needs.

24 THE CHAIRMAN: And the financing of
25 them?

26 DR. THOMSON: The two agencies
27 mentioned, the government with its present large contri-
28 bution and the voluntary agencies in whatsoever manner
29 it can be obtained from their set-up. We recognize,
30 for instance, that the cancer foundations do exist in



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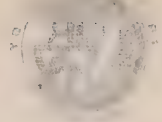
2 THE CHAIRMAN: Just passing through
3 my mind in the background of the question, would this
4 type of thing fit into an over-all health services
5 programme to set up partially supported by federal moneys
6 and partially by provincial moneys?

7 DR. THOMSON: It seems to us under a
8 foundation we often times have that added co-operation
9 and interest which is produced by the voluntary agencies
10 which leads to a better handling of the whole situation.
11 I would feel if it would lead to a better handling, one
12 which is more progressive, more capable of carrying out
13 and following of research projects, that it would be in
14 the best interests of the people.

15 DR. GRISDALE: I think the only other
16 point that is of importance in this regard is that we
17 feel that there is some reason to believe that the
18 general direction that we have given to a cancer service
19 by a commission or foundation might be such as to, in
20 the long range way, make the stability of the organization
21 and the research facilities that they had and the moneys
22 they were able to spend on research were a little more
23 stable than those under the set up of a department of
24 government.

25 DR. THOMSON: We have not attempted
26 to outline the mechanism behind the foundation -- we have
27 not attempted to outline in this recommendation the
28 mechanism behind the foundation at all.

29 COMMISSIONER BALTZAN: Dr. Thomson
30 and gentlemen, I compliment you for your joint effort in



other areas and they seem to work very well.

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COMMISSIONER KATHAN: Dr. Thomson

and gentlemen, I compliment you for your joint effort in



1 combining your three major organizations including the
2 University. It shows an unity of mind and action and
3 also will spare us reading three briefs.

4 I would like to continue on the same
5 thing, the same good spirit and refer to page S2,
6 paragraph C which you put forward in the form of a
7 recommendation. I won't read the whole thing but merely
8 state:

9 "..... the head of any clinical
10 department of the medical school must also
11 be the director of the equivalent clinical
12 department in the main teaching hospital..."

13 My question is: Do you seriously
14 imply that this should be something that this Commission
15 should rule in the way of a recommendation? Do you
16 mean seriously we should do this or is this not really
17 a matter of local arrangement, local options?

18 DR. THOMSON: Dr. Thompson, would
19 you care to answer Dr. Baltzan?

20 DR. THOMPSON: We feel that this is
21 a very important part of the education in the clinical
22 aspects of medicine. Our recommendation here, I think,
23 is one which we feel should apply across the country;
24 it is not a local situation. We feel in the best
25 interests of medical education in any university the head
26 of the department in many universities should be the
27 head of the clinical department in the teaching hospital.

28 COMMISSIONER BALTZAN: One might
29 agree and one might not, but I asked for your point of
30 view. How successfully have you been able to establish



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COMMISSIONER WALTMAN: One might

agree and one might not, but I asked for your point of

view. How successfully have you been able to establish



1 that principle here?

2 DR. THOMPSON: It has worked very well.

3 I might refer to Dr. Wilson who occupies this position.

4 DR. WILSON: I can just endorse what

5 Dr. Thompson has just said that in the education of

6 medical students and in the continuing education of

7 graduate students this particular interlocking of offices

8 is necessary. It has been tried in the opposite direction

9 where the head of the department in the university is not

10 the chief of medicine in the main teaching hospital and

11 this led to a dissolution of this arrangement within three

12 years of its beginning in one of our three leading medical

13 schools in this country. To the best of my knowledge

14 this has not again happened.

15 COMMISSIONER BALTZAN: Dr. Wilson,

16 the manner in which you answered that question raised this

17 point in my mind, that perhaps your concern is with,

18 say, the faculty chief or professor being the chief of

19 the department of, say, medicine or surgery in the

20 related university hospital, is that your concern?

21 DR. WILSON: Yes, and also if

22 THE CHAIRMAN: May I ask you if

23 you would speak a little louder, Dr. Wilson. The acoustics

24 here are not the best.

25 DR. WILSON: I am sorry, sir.

26 I think if the head of any teaching department is

27 responsible to the deans department for the instruction

28 of students, that he must have the prerogative to appoint

29 the teachers who are going to teach the students regard-

30 less of what teaching hospital this may take place in.



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30 less of what teaching hospital they may take place in.



1 COMMISSIONER BALTZAN: In other
2 words, you want this to carry over to your affiliated
3 teaching hospitals?

4 DR. WILSON: Right.

5 COMMISSIONER BALTZAN: Have you done
6 so here in Edmonton?

7 DR. WILSON: I am not speaking for
8 all the departments, but this is happening in our
9 affiliated teaching departments when appointments are
10 always made by mutual arrangements between the board of
11 management of the affiliated teaching hospitals. I am
12 thinking of the most recent one, in the University
13 Department.

14 COMMISSIONER BALTZAN: That is exactly
15 the word I was looking for, by a mutual arrangement rather
16 than appointment direct, in other words, the local
17 autonomy of the affiliated teaching hospital has a
18 considerable amount to say about the selection of the heads
19 of their departments?

20 DR. WILSON: In most instances, there
21 is an agreement as to who this person should be.

22 COMMISSIONER BALTZAN: By consultation?

23 DR. WILSON: Yes.

24 COMMISSIONER BALTZAN: Thank you, one
25 other thing, on page 4. I am very much interested in
26 this question of teaching. Your recommendation in
27 paragraph 6 2(b):

28 "Expansion and improvement in the
29 out-patient department of our main teaching
30 hospital is necessary."



COMMISSIONER BARTMAN: In other

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other thing, on page 4, I am very much interested in

this question of paragraph 4. Your recommendation in

paragraph 6 (b):

"Expansion and improvement in the

out-patient department of our main teaching

hospital is necessary."



How do you find the present order of things, say, more particularly in the western provinces, do people tend to go to out-patient clinics in your University Hospital and in your affiliated teaching hospitals any where near to the extent they go in the large metropolitan areas such as Toronto and Montreal?

DR. THOMSON: I wonder if Dr. Wilson or Dr. Goodhill might answer that. They are intimately acquainted with the situation in the west.

we perhaps should make one point of distinction at the out-set in discussing out-patient medical care. This one has to recognize that certainly in our main teaching hospitals that there is an emergency department where acute illness is taken care of and in addition to this, there is an out-patient department. I hope this will not be confusing, under the control of the full time staff.

Now, any one -- no person is turned away from the emergency department. That is what it is there for. The out-patient department exists for the provision of medical care for those people who are unable, by virtue of financial resources, to provide their own medical care. This is provided by the staff of our main teaching hospitals on a voluntary service.

in this connection is that with the increasing tendency for people to have their own doctor, "My doctor", the tendency to attend an out-patient department is decreasing and if that is the tendency, then do you feel it is going



1 reflect itself upon the preparation and teaching of
2 medical students and graduates in their courses of
3 preparation in the future?

4 DR. WILSON: Well, Dr. Baltzan, it
5 is not so here. As a matter of fact, the exact reverse
6 situation exists. There are two reasons for this, and
7 this was discussed recently on a national level, about
8 the problem of teaching students. The attendance at our
9 out-patient departments is climbing so much, it has only
10 been open a little over a year and it is already taxed
11 to capacity. There are two reasons for this: One, for
12 the first time we have had an out-patient department
13 which is an integral part of our main teaching hospital
14 and the second point is, at the time this move was made,
15 from divorced quarters to a central unit, that there was
16 a reversal in the economy of the times. These are the
17 two main factors that have resulted in an increase in
18 the out-patients to a point where it is completely
19 satisfactory for the instructing of under-graduate
20 students.

21 COMMISSIONER BALTZAN: Dr. Wilson,
22 does the same thing reflect itself in relation to the
23 other city hospitals?

24 DR. WILSON: The other city hospitals,
25 Dr. Baltzan, don't have out-patient departments, as such.
26 They have emergency areas for the treatment of acute
27 illness, but the out-patient department of the University
28 Hospital is one where people who have met the means
29 test if you like, then become the permanent patients of
30 the department.



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1 COMMISSIONER BALTZAN: How do the
2 internes fair in those other hospitals, not having any-
3 thing but the emergency kind of cases to learn by?

4 DR. WILSON: I think I can answer
5 that question by saying -- Dr. Thomson might add to this
6 or Dr. Greenhill -- our medical school has, almost from
7 its inception, made a policy of teaching on all patients
8 regardless of their financial background. We feel, and
9 always have felt, if one teaches with ones own patients
10 that it is the best way a student can learn this very
11 necessary part of patient care, the relationship between
12 the doctor and his patient. We have had no difficulty
13 at any time, in my knowledge, and certainly you couldn't
14 have a better type than teaching on any type of patient
15 who presented an interesting problem.

16 As a matter of fact, the intelligent
17 patient, regardless of his status, takes great interest
18 in this.

19 COMMISSIONER BALTZAN: I am very
20 glad, and one of the reasons I brought this up was because
21 I had hoped that would be the answer, and it would go on
22 the public record. That is generally not a usual concept.

23 Number 31, and I think I am through,
24 page 9:

25 "Alberta was one of the first provinces
26 to recognize the need for some control of
27 persons calling themselves specialists."

28 Is that act still in existence, the
29 one, I think it is, of 1926?

30 DR. THOMSON: Yes, sir.



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1 COMMISSIONER BALTZAN: Has it filled
2 its purpose, sir?

3 DR. BRAMLEY-MOORE: Yes, sir.

4 COMMISSIONER BALTZAN: Do the
5 voluntary integral departments and medical organizations
6 like the American Board or the Royal College better meet
7 that need, or was this Act sufficient unto itself?
8 DR. BRAMLEY-MOORE: With the
9 establishment of the Royal College of Physicians and
10 Surgeons of Canada it reduced the problem of the University
11 of Alberta in determining who might be adequately
12 qualified and who might not be adequately qualified.

13 COMMISSIONER BALTZAN: Can you commit
14 yourself which is the one you rely on for your decision,
15 can one still have recourse to application for specialist
16 under the terms of this act or is it automatic by virtue
17 of these other qualifications?

18 DR. BRAMLEY-MOORE: We touched on
19 that in the requirements of the University of Alberta
20 relating to recognition of specialists and you will note
21 that the applicants are required to be certified by the
22 Royal College of Physicians and Surgeons or by their
23 fellowship. It is a requisite.

24 COMMISSIONER BALTZAN: And then, do
25 they have to apply under the terms of the act also?

26 DR. BRAMLEY-MOORE: They must apply
27 under the act, sir, and they must submit credentials
28 relating to their training; their documents are reviewed
29 by a Committee, set up of the General Faculty Council
30 of the University of Alberta. The Committee also takes



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1 into consideration the quality of care that the individual
2 has been providing between the time he entered practice
3 in the province and the time his application is being
4 reviewed by the Committee.

5 COMMISSIONER BALTZAN: In other words,
6 it is automatically contingent upon the submission?

7 DR. BRAMLEY-MOORE: Practically,
8 there are cases in the province that haven't been
9 recognized.

10 COMMISSIONER BALTZAN: Thank you very
11 much.

12 THE CHAIRMAN: Miss Girard?

13 COMMISSIONER GIRARD: Dr. Thomson,
14 I am rather intrigued by the fact what has been considered
15 so far in many provinces as a public health nursing
16 function seems to have been given to the Mounties in this
17 province; by that I am referring to the dermatological
18 investigation of V.D. cases. Is this because the Mounties
19 always get their man?

20 DR. THOMSON: Miss Girard, some times
21 they happen to be women.

22 COMMISSIONER GIRARD: Why is this done
23 in this way? It really intrigues me because I have always
24 thought it a public health nursing function.

25 DR. THOMSON: This is an arrangement,
26 Miss Girard, which was made within the department and
27 it probably served its purpose in some of the far outlying
28 areas because particularly in these areas where this
29 applies -- we recognize the inadequacy of that. Certainly
30 when the policeman arrives, I am sure people take to the



1 hills. We feel that this could be changed so that
2 personnel adequately trained within the department would
3 be able to carry out this function rather than to ask
4 some other branch.

5 COMMISSIONER GIRARD: How is it
6 carried out in the cities, in Edmonton and Calgary? Is
7 that just in the rural areas or also in the cities?

8 DR. THOMSON: I believe that operates
9 in the cities. I can't give you a frank answer to that.
10 I would assume that it was.

11 COMMISSIONER GIRARD: I wonder what
12 the neighbours think when they see a Mountie going in to
13 visit the family?

14 DR. McPHERSON: Miss Girard, I think
15 it is in reference to these persons who have been named
16 as contacts that are reluctant to appear at the clinic.
17 Under the Act it is compulsory.

18 COMMISSIONER GIRARD: I know a lot
19 of provinces have this Act, but never use it. They try
20 to have public health nurses be persuasive enough to get
21 the patient to come back.

22 I am also interested in your day care
23 centres on page 53. Are these day care centres for all
24 types of illnesses, or are these more or less like
25 hospitals out-patient, psychiatric patients coming back
26 to the hospital for treatment?

27 DR. THOMSON: Miss Girard, these
28 centres may take care of a variety or a large number of
29 people. The basic principle would be that they are not
30 really sick enough to get an active treatment bed, but



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personnel adequately trained within the department would

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that just in the rural areas or also in the cities?

DR. THOMSON: I believe that operates

in the cities. I can't give you a frank answer to that.

I would assume that it was.

COMMISSIONER GIRARD: I wonder what

the neighbours think when they see a Montebello in to

visit the family?

DR. McPHERSON: Miss Girard, I think

it is in reference to these persons who have been named

as contacts that are reluctant to appear at the clinic.

Under the Act it is compulsory.

COMMISSIONER GIRARD: I know a lot

of provinces have this Act, but never use it. They try

to have public health nurses be persuasive enough to get

the patient to come back.

I am also interested in your day care

centres on page 53. Are these day care centres for all

types of children, or are there more or less like

hospitals out-patient, psychiatric patients coming back

to the hospital for treatment?

DR. THOMSON: Miss Girard, these

centres may take care of a variety or a large number of

people. The basic principle would be that they are not

really sick enough to get an active treatment bed, but



1 they do require to be in the routine of the hospital for
2 education, for tests, and for continuing therapy, so
3 these day care centres might have people who return, say,
4 on a psychiatric basis. We have group therapy going on.
5 They might be diabetics who would be coming in for
6 lectures. They might be for individuals from a distance
7 coming in, or diagnostic studies where it isn't necessary
8 to be in a hospital. There might be provision made for
9 hospital type treatment, although basically we are
10 concerned with the space in association with the
11 hospitals at which tests might be obtained, or the said
12 investigation, the lectures given, or the continuing
13 care or type of treatment carried out. Dr. Greenhill
14 may add some comment in respect to that, Miss Girard.

15 DR. GREENHILL: I would just say
16 further these ambulatory patients who doesn't require
17 hospitalization, but are undergoing investigation and
18 being educated in their disease are also the type of
19 patient that many medical students don't see. This would
20 add to their learning experience.

21 COMMISSIONER GIRARD: Would you say
22 this is part of the hospital organization, or something
23 separate?

24 DR. THOMSON: I think it should be
25 part of the hospital, direct relationship to it.

26 COMMISSIONER GIRARD: Yes, if you
27 want the internes to be able to use the facilities of
28 these day care centres.

29 DR. GREENHILL: And continuity of
30 medical records.



1 they do require to be in the routine of the hospital for
2 education, for tests, and for continuing therapy, so
3 these day care centres might have people who return, say,
4 on a psychiatric basis. We have group therapy going on.
5 They might be diabetics who would be coming in for
6 lectures. They might be for individuals from a distance
7 coming in, or diagnostic studies where it isn't necessary
8 to be in a hospital. There might be provision made for
9 hospital type treatment, although basically we are
10 concerned with the space in association with the
11 hospitals at which tests might be obtained, or the kind
12 investigation, the lectures given, or the continuing
13 care or type of treatment carried out. Dr. Greenhill
14 may add some comment in respect to that, Miss Girard.
15 DR. GREENHILL: I would just say
16 further these ambulatory patients who don't require
17 hospitalization, but are undergoing investigation and
18 being educated in their disease are also the type of
19 add to their learning experience.
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21 this is part of the hospital organization, or something
22 separate?
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24 part of the hospital, direct relationship to it.
25 MISS GIRARD: Yes, if you
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27 these day care centres.
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1 COMMISSIONER GIRARD: That would be
2 part of the hospital?

3 DR. GREENHILL: Yes.

4 COMMISSIONER GIRARD: Thank you very
5 much.

6 THE CHAIRMAN: We will take a short
7 recess.

8
9 --- Short recess.

10
11 COMMISSIONER VAN WART: Turning to
12 section 245 regarding under-graduate recruitment, I think
13 probably I would direct the question of the University
14 officials.

15 Is this detailed plan which you outline
16 unique among universities of Canada?

17 DR. THOMPSON: I know of no feature
18 that is unique. I do not know of any others that have all
19 of these features in this plan. We have done everything
20 we think reasonable to try to interest students in
21 medicine.

22 COMMISSIONER VAN WART: Has it
23 resulted in a larger number of people becoming interested
24 and applying?

25 DR. THOMPSON: It is always hard to
26 say what has been, because we in the last two years have
27 had a very definite increase in the applicants, and the
28 applicants who are good enough to be admitted. Two years
29 ago we admitted fifty-five students, I think, and last
30 year, sixty-four. This year, we admitted seventy-six.



1 We feel that it is partly the recruitment programme, and
2 partly the fact that the whole university population is
3 increasing and we are just getting our proportion of the
4 increase.

5 COMMISSIONER VAN WART: Are you
6 finding the number of applicants coming forward are not
7 of the type that can meet your pre-medical standards?

8 DR. THOMPSON: We are finding that
9 more of them are meeting them, sir, but there is a
10 difference meeting the standards and being exactly the
11 type of students we want.

12 We feel that our standard -- our basic
13 standard -- is set about as low as we can set it to have
14 a reasonable chance that the student will succeed in
15 medical school. We, of course, would like to see all
16 students coming in as A-students, but we do not get that.
17 We would get ten per cent or fifteen per cent, maybe as
18 high as twenty per cent in certain years applying. The
19 rest are lower.

20 COMMISSIONER VAN WART: Do you make
21 a concentrated drive for A students when you are going
22 around in your educational programme?

23 DR. THOMPSON: We would certainly
24 try to interest the best students. It is pretty hard to
25 pitch things entirely to them, but we do our very best
26 to interest the best students in our programme.

27 COMMISSIONER VAN WART: Of your first
28 year students, are there many who come from outside the
29 province?

30 DR. THOMPSON: Not as a rule, sir.



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COMMISSIONER VAN WART: Of your first

year students, are there many who come from outside the

DR. THOMPSON: Not as a rule, sir.



1 Since both Saskatchewan and British Columbia have opened
2 their medical schools, we get very few from outside of
3 Alberta. The odd individual who may have relatives here
4 and find it easier to go to medical school here may come,
5 after having taken pre-medical elsewhere. The occasional
6 one comes from the U.S. The percentage would be very
7 small -- no more than four or five in any individual year.

8 COMMISSIONER VAN WART: Do these who
9 come from outside the province, after they graduate,
10 tend to remain in the province or go away?

11 DR. THOMPSON: I did a general
12 survey on this, and this is quite interesting. This
13 includes one from Saskatchewan and one from British
14 Columbia. It shows that two-thirds of the students
15 who come to us from Alberta stay here, but approximately
16 only one-third of the students from outside of Alberta
17 stay here.

18 COMMISSIONER VAN WART: Do you feel
19 that you have reached the point of maximum number of
20 students coming to University from the province, or do
21 you feel this increase will go on for a few years yet?

22 DR. THOMPSON: We certainly hope it
23 will go on, and we think it will. It is much too early,
24 however, to tell yet. The indication is that for next
25 year we will have at least as many good applicants. And
26 in fact it looks like more at the moment.

27 COMMISSIONER VAN WART: When do you
28 anticipate you will meet the point of saturation which
29 you can handle in your University?

30 DR. THOMPSON: For the medical



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3 Alberta. The odd individual who may have relatives here
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6 one comes from the U.S. The percentage would be very
7 small -- no more than four or five in any individual year
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9 COMMISSIONER VAN WART: Do these who
10 come from outside the province, after that period,
11 tend to remain in the province or go away?
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13 DR. THOMPSON: I did a general
14 survey on this, and this is quite interesting. This
15 includes one from Saskatchewan and one from British
16 Columbia. It shows that the bulk of the students
17 who come to us from Alberta stay here, but approximately
18 only one-third of the students from outside of Alberta
19 stay here.
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21 COMMISSIONER VAN WART: Do you feel
22 that you have reached the point of maximum number of
23 students coming to University from the province, or do
24 you feel this increase will go on for a few years yet?
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26 DR. THOMPSON: It certainly looks as
27 if we are going to reach it. It is much too early,
28 however, to tell yet. The indication is that for next
29 years we will have at least as many good applicants. And
30 in fact it looks like more at the moment.
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32 COMMISSIONER VAN WART: When do you
33 anticipate you will meet the point of saturation which
34 you can handle in your University?
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36 DR. THOMPSON: For the medical



1 faculty, sir, we state here that we would like to
2 eventually turn out one hundred and twenty students. I
3 would certainly hate to see us go higher than that,
4 because by that time it would be too big a student body.

5 COMMISSIONER VAN WART: Have you any
6 date when you think you will arrive at that stage?

7 DR. THOMPSON: We have placed this
8 at 1980. We think that if the student population as a
9 whole increases the way we are told it will, that we will
10 probably reach that, with continued success of recruit-
11 ment.

12 COMMISSIONER VAN WART: I see.

13 THE CHAIRMAN: Before you leave that,
14 that one hundred and twenty in that projection will be
15 sufficient to take care of the needs of Alberta?

16 DR. THOMPSON: Yes, sir, with the
17 projected increase in population.

18 COMMISSIONER VAN WART: Section 139
19 and 140, Dr. Thomson, is pertaining to your Motor Vehicle
20 Hospital Indemnity Act.

21 Would you enlarge upon those two
22 sections, Dr. Thomson, for me; Sections 139, 140.

23 DR. THOMPSON: I think Dr. Bramley-
24 Moore could give you the details of this from the legal
25 point of view, but as specifically indicated here the
26 hospital medical costs may be paid for those people who
27 are injured in motor accidents anywhere in the province
28 of Alberta under this specific Indemnity Act.

29 Dr. Bramley-Moore, would you care to
30 talk to Dr. Van Wart concerning this?



Faculty, sir, we agree here that we would like to eventually turn out one hundred and twenty students. I would certainly hate to see us go higher than that, because by that time it would be too big a student body.

COMMISSIONER VAN WART: Have you any

data when you think you will arrive at that stage?

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COMMISSIONER VAN WART: I see.

DR. C. ALLEN: Before you leave that, that one hundred and twenty in that population will be sufficient to take care of the needs of Alberta.

DR. THOMPSON: Yes, sir, with the projected increase in population.

COMMISSIONER VAN WART: Section 13, and Mr. Dr. Thompson, as pertaining to your Honor Verdict Hospital Indemnity Act.

Would you enlarge upon those two sections, Dr. Thompson, (c) and (d)?

DR. THOMPSON: I think Dr. Freeman-

Moore could give you the details of both the legal point of view, but as specifically indicated here the hospital medical costs may be paid for those people who are injured in motor accidents anywhere in the province of Alberta under this specific indemnity Act.

Dr. Freeman-Moore, would you care to

Bring to Dr. Van Wart concerning this?



1 COMMISSIONER VAN WART: I will have
2 your explanation first, then.

3 DR. BRAMLEY-MOORE: Well, sir, the
4 background of it is that the provincial government charges
5 \$1.00 with the annual licensing fee and that goes into
6 the unsatisfied judgment fund, and as we have reported
7 here, if an individual is injured in a car accident and
8 is unable to recover the costs of those from the respon-
9 sible party, the costs will be paid for out of the fund.

10 I cannot give you the full legal
11 procedures for recovery. I believe there are occasions
12 when there must be a claim adjudged to by a court.

13 THE CHAIRMAN: Must be reduced to
14 judgment?

15 DR. BRAMLEY-MOORE: Yes, sir.

16 I cannot give you the exact detail of
17 that, but it does give protection to individuals who are
18 injured. It gives protection to hospitals which have
19 provided the service where it is difficult to collect
20 the moneys.

21 COMMISSIONER VAN WART: Under section
22 140 ---

23 THE CHAIRMAN: Pardon me. Although
24 there are contingencies where no judgment is possible --
25 I mean, the hit and run driver where there is nobody to
26 get a judgment against?

27 DR. BRAMLEY-MOORE: Yes. They would
28 be able to collect.

29 COMMISSIONER VAN WART: The money in
30 section 140 is paid over to the College?



Your explanation first, then.

MR. BRADLEY-MOORE: Well, sir, the

background of it is that the provincial government has
\$2.00 with the annual licensing fee and that goes into
the unattached judgment fund, and as we have reported
here, if an individual is injured in a car accident and
is unable to recover the costs of those from the respon-
sible party, the costs will be paid for out of the fund.

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MR. BRADLEY-MOORE: Yes. They would

be able to collect.

COMMISSIONER VAN WART: The money in

section 120 is paid over to the College?



1 DR. BRAMLEY-MOORE: No, sir. The Act
2 gives the Minister power to enter into agreement with the
3 College, but the agreement has never been entered into.
4 There were certain problems relating to determining the
5 amount of money that might be involved, and it is opera-
6 ting directly from the fund. There is no agreement
7 between the organizations.

8 COMMISSIONER VAN WART: The doctor
9 bills the fund?

10 DR. BRAMLEY-MOORE: That is correct, sir.

11 COMMISSIONER VAN WART: Is it full
12 payment or pro-ration?

13 DR. BRAMLEY-MOORE: No, sir. He is
14 paid his fee. There are occasions when the department
15 may request advice from us as to the equity of the fee.

16 COMMISSIONER VAN WART: In the final
17 analysis, then, the department controls the fee?

18 DR. BRAMLEY-MOORE: No, sir. In many
19 instances one receives a fee or is charged a fee and one
20 may feel that the fee is not equitable. In the case of
21 courts, I understand they have a procedure whereby it
22 would be referred to the clerk of the court or to a
23 judge, and the judge would determine whether or not the
24 fee was an adequate fee or a correct fee. This is
25 somewhat a similar situation. If the administrators
26 of the fund have some reason to question the fee, they
27 refer it over to us and ask our advice as to whether we
28 believe it is a correct fee for the procedures rendered.
29 It is similar to mediation committees that are set up
30 by most professional organizations across Canada.



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1 COMMISSIONER VAN WART: You use the
2 word "department". What do you mean by that?

3 DR. BRAMLEY-MOORE: It is the
4 Highways Department, sir.

5 THE CHAIRMAN: The supervisory of the
6 fund.

7 COMMISSIONER VAN WART: Yes, I see.

8 Turning now to section 200, the Treat-
9 ment Services Act. Is that in force at the present time
10 or just on the books?

11 DR. THOMSON: No, Dr. Van Wart. This
12 act is not in force; it is on the books of the province
13 of Alberta. It has not been implemented.

14 DR. BRAMLEY-MOORE: I would just
15 differentiate a little. The act is in force but no
16 agreement has been entered into between the government
17 and any of the voluntary agencies.

18 COMMISSIONER VAN WART: I notice that
19 section D states what the act will cover, but in section
20 201 in the last sentence you are in disagreement with
21 some provision in the act. Would you explain that. It
22 is as follows:

23 "We believe that legislation might
24 be amended to provide subsidy to those
25 below a certain income level according to
26 their need."

27 DR. THOMPSON: Yes, sir. This act
28 provides for assistance on the part of the government, a
29 subsidy to all people taking out insurance. It is the
30 feeling of the profession that subsidy should not be given



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word "department". What do you mean by that?

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port Services Act. Is that in force at the present time

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section 2 states that the act will cover, but in section

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provides for assistance on the part of the government, a

subsidy to all people taking out insurance. It is the

feeling of the profession that subsidy should not be given



1 to all people -- those who can afford, as well as those
2 who cannot afford. Our suggestion here would be that
3 even although implementation of this or a signed agreement
4 would reduce the number of people of the low income group
5 who could not afford -- in other words, by their
6 assistance they would have been able to pay -- it would
7 not seem reasonable to pay or subsidize all when we are
8 concerned only with a specific needy area, and we would
9 recommend an amendment so that it would permit the
10 government to subsidize those people who need, as opposed
11 to all people.

12 COMMISSIONER VAN WART: Thank you.
13 That is all, Mr. Chairman.

14 COMMISSIONER FIRESTONE: Dr. Thomson,
15 you have set out in paragraph 114 of your summary and
16 recommendations the main objectives of your group here
17 in Alberta, and you say that the main objective is, and
18 I quote:

19 "Ensuring that the best possible
20 health services be available to all Canadians."

21 DR. THOMSON: Yes, sir.

22 COMMISSIONER FIRESTONE: You proceed
23 in paragraph 56 to elaborate on what you mean and how
24 you expect that this objective can be achieved in the
25 province of Alberta, and I quote:

26 "That coverage provided by a plan
27 should be comprehensive and without exclusions
28 or major deterrents."

29 I wonder, Dr. Thomson, whether we could
30 have a little discussion and arrive at an understanding



to all people -- those who can afford, as well as those

assistance they would have been able to pay -- it would

not seem reasonable to pay or subsidize all when we are

concerned only with a specific needy area, and we would

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COMMISSIONER VAN WAH: Thank you.

COMMISSIONER FINESTOWN: Mr. Thompson,

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"Ensuring that the best possible

health services be available to all Canadians.

MR. THOMPSON: Yes, sir.

in paragraph 56 to elaborate on what you mean and how

you expect that this objective can be achieved in the

province of Alberta, and I quote:

"That coverage provided by a plan

should be comprehensive and without exclusions

or major determinants."

I wonder, Mr. Thompson, whether we could

have a little discussion and arrive at an understanding



1 of what you mean by some of the elements in this
2 definition, and would you first be good enough to explain
3 to us what you mean by a plan which should be comprehen-
4 sive and without exclusions?

5 DR. THOMSON: Yes, sir.

6 This paragraph 56 attempts to explain
7 our attitude towards the provision of one segment of
8 health services, and that is in the provision through
9 pre-payment of medical services insurance.

10 Now, under medical services insurance
11 we feel that a plan should be comprehensive. In other
12 words, that no physicians service should be excluded. If
13 possible, the patient seeking assistance should have
14 available to him any or all physicians service.

15 Now, in many previous plans because of
16 expense, cost, they had exclusions, and for a long time
17 mental illness was an exclusion; arthritis, in some areas,
18 was an exclusion.

19 We have pressed for our plan on the
20 recommendation of the Association and the College to cover
21 all medical illness and with very few exceptions this is
22 so under our plan.

23 The exceptions which might be needed at
24 the present time with regard to which they are continuing
25 to study and work so that they might make them available
26 without too great an expense are the provision of glasses,
27 optical examinations, and the provision of routine
28 medical examinations. I believe that those two exceptions
29 of other physicians services are covered. This is what
30 I mean by comprehensive.



1 of what you mean by some of the elements in this

2 definition, and would you like to be good enough to explain

3 to me what you mean by a plan which should be comprehensive

4 and without exceptions?

5 DR. THOMAS: Yes, sir.

6 This paragraph is intended to explain

7 the addition to the provision of one element of

8 positive service, and that is in the provision through

9 pre-payment of medical services insurance.

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12 words, that no physician service should be excluded. If

13 possible, the physician service should have

14 available to him any of all physician service.

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16 expense, cost, they had exceptions, and for a long time

17 medical insurance was an exception, sometimes, in some areas

18 was an exception.

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20 recommendation of the Association and the College to cover

21 all medical services and with very few exceptions this is

22 no longer our plan.

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24 the present time with regard to which they are continuing

25 to study and work to find they might make them available

26 without too great an expense and the provision of glasses,

27 optical examinations, and the provision of routine

28 medical examinations. I believe that those two exceptions

29 I mean by comprehensive.



1 COMMISSIONER FIRESTONE: Thank you,
2 Dr. Thomson. You have referred very much to a plan as
3 you have it in operation in the Province of Alberta. I
4 am raising the question, sir, in terms of a principle
5 assuming that there may be an extension of medical care
6 services beyond what you already have in operation in
7 the province, and I am wondering whether the principle
8 which you have just announced which applies to your own
9 plan would be applicable to a broader programme for the
10 province of Alberta?

11 DR. THOMSON: The principles, as I
12 have indicated them, would be applicable to the provision
13 of physicians services.

14 COMMISSIONER FIRESTONE: All across
15 the province of Alberta?

16 DR. THOMSON: To anyone who was
17 requiring physicians services. I am not quite sure what
18 you mean by a broader plan. Do you mean extended services?

19 COMMISSIONER FIRESTONE: I understood
20 from you, Dr. Thomson, in answer to my question you
21 suggested that your present plan, the Alberta Medical
22 Insurance Plan, which the medical profession has sponsored,
23 follows certain principles, and you have elaborated them.
24 My question was not with reference to the plan which is
25 in operation now, but with respect to a set of principles
26 that would apply to medical care services for all the
27 people of Alberta. I take it from what you have said
28 that you would feel that the same principle which you
29 apply to your plan, which only covers a limited number,
30 would also apply to all medical services to be provided



1 to all the people of Alberta?

2 DR. THMSON: Yes, sir. I am sorry.

3 We would mean that exactly.

4 COMMISSIONER FIRESTONE: Yes. Thank
5 you very much.

6 Assuming that such a plan were developed,
7 do I understand that the term "comprehensive" covers
8 pre-payment of all the costs involved of such service as
9 you have enumerated? All the costs?

10 DR. THOMSON: I think the word
11 "comprehensive" there is used to include the range of
12 illnesses which might be covered. It really has not to
13 do with the costs per se.

14 COMMISSIONER FIRESTONE: I appreciate
15 that.

16 Can we perhaps develop going from the
17 term of comprehensive services to the cost for comprehen-
18 sive services.

19 Would your group be in favour that the
20 pre-payment plan covers all the costs for comprehensive
21 services?

22 DR. THOMSON: Well, Mr. Firestone, I
23 think one would have to go back to the consideration of
24 the position of the profession in Alberta with regard to
25 their fee schedule. Herein we have developed a fee
26 schedule which is somewhat different to other areas in the
27 country, where there is a single schedule. Under this
28 system, one fee is allowed for one service but the right
29 is given, as I explained some short time ago, to specialists
30 in certain areas to extra-bill.



1 to all the people of Alberta?

2 DR. THOMSON: Yes, sir. I am sorry.

3 We would mean that exactly.

4 Not very much.

5 Assuming that such a plan were developed

6 do I understand that the term "comprehensive" covers

7 pre-payment of all the costs involved of such services as

8 you have mentioned? All the costs?

9 DR. THOMSON: I think the word

10 "comprehensive" there is used to include the range of

11 illnesses which might be covered. It really has not to

12 do with the costs per se.

13 COMMISSIONER WILSON: I appreciate

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15 Can we perhaps develop going from the

16 point of comprehensive services to the cost for comprehen-

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18 Would your group be prepared to take the

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20 services?

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22 the position of the profession in Alberta with regard to

23 their fee schedule. Herein we have developed a fee

24 schedule which is somewhat different to other areas in the

25 country, where there is a single schedule. Under this

26 system, one fee is allowed for one service but the right

27 is given, as I explained some short time ago, to specialists

28 in certain areas to extra-bill.



1 Now, the premium which is paid for this
2 insurance permits, I think, of the individual receiving
3 the coverage, but it still leaves this area in which he
4 might be extra-billed. This seems to be the most workable
5 arrangement we can develop at this time rather than have
6 a double schedule in which all costs are covered, both
7 the specialist and non-specialist.

8 COMMISSIONER FIRESTONE: Would it be
9 difficult to develop a schedule that covers all medical
10 care services?

11 DR. THOMSON: It is not difficult
12 to develop it but the expense is rather greater.

13 COMMISSIONER FIRESTONE: Well, it
14 depends, does it not, whether your group is in favour of
15 a medical care programme which will cover all the costs
16 of the medical care services or not? Now, you are either
17 in favour of a programme that covers all the costs or you
18 are not in favour. What I would like to elicit from you
19 is whether or not you are in favour of a programme that
20 covers all the costs of a medical care service for the
21 province of Alberta.

22 DR. THOMSON: I think, again, one
23 cannot give a direct answer to that. I am not trying to
24 hedge to any degree but according to our concepts of
25 developing a programme or rather a fee schedule which
26 could be met by the people -- we must remember this was
27 established prior to thinking in terms of large pre-payment
28 or total pre-payment -- it was felt that the interests of
29 the doctors, specialists and general practitioners and
30 the interests of the patients who are going to receive



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2 insurance permits, I think, of the individual receiving
3 the coverage, but it still leaves this area in which he
4 might be extra-billed. This seems to be the most workable
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6 a double schedule in which all costs are covered, both

7
8 COMMISSIONER THOMPSON: Would it be
9 difficult to develop a schedule that covers all medical
10 care services?
11 DR. THOMPSON: It is not difficult

12 to develop it but the expense is rather greater.
13
14 COMMISSIONER THOMPSON: Well, is
15 dependent, does it not, whether your group is in favour of
16 a medical care programme which will cover all the costs
17 of the medical care services or not? Now, you are either
18 in favour of a programme that covers all the costs or you
19 are not in favour. What I would like to elicit from you
20 is whether or not you are in favour of a programme that
21 covers all the costs of a medical care service for the
22 province of Alberta.

23 DR. THOMPSON: I think, again, one
24 cannot give a direct answer to that. I am not trying to
25 hedge to any degree but according to our concept of
26 developing a programme on rather a fee schedule which
27 could be met by the people -- we must remember this was
28 established prior to thinking in terms of large pre-payment
29 or total pre-payment -- it was felt that the interests of
30 the doctors, specialists and general practitioners and
31 the interests of the patients who are going to receive



1 this service would be served best by such a fee schedule
2 in which there is this degree of extra billing. I have
3 indicated we do not allow or it does not happen very much
4 but it still gives the doctor, that specialist, the
5 inherent right to charge that extra for his particular
6 field of specialty. That is recognized by the people and
7 under this system we can provide now a fee schedule which
8 is reasonable, and we can provide a fee schedule which
9 can be operative in a premium system which is also
10 acceptable to the people. To say now "Do we want it all
11 paid for?", we would like to see a system such as this in
12 which a patient will be able to receive all services and
13 for which he will be able to pay as far as costs are
14 concerned except where he wishes to take advantage of some
15 particular thing such as an extra or additive service
16 in which area he could expect to be extra billed but he
17 would know that ahead of time.

18 COMMISSIONER BALTZAN: Under your
19 scheme the people do get adequate medical service?

20 DR. THOMSON: Undoubtedly, sir.

21 COMMISSIONER FIRESTONE: Well, you have
22 explained to us that this system, as you have described
23 it now in Alberta, is in the process of evolution, histor-
24 ical development and you found that it works?

25 DR. THOMSON: Yes, it does.

26 COMMISSIONER FIRESTONE: In posing the
27 question to you I do not suggest your system is not
28 effective at the moment but assuming that the people would
29 like to have an improvement in the existing system, what
30 we are trying to elicit here is how such a system could



1 be developed and how it can be improved. Now, I take it
2 from what you have been saying that you and your
3 associates are in favour of the pre-payment principle for
4 medical care services?

5 DR. THOMSON: Yes, sir.

6 COMMISSIONER FIRESTONE: Now, why could
7 that pre-payment principle not be applied to all medical
8 care costs? Why do you have to say "We go to this point,
9 not up to that point"? Why?

10 THE CHAIRMAN: You mean as a matter
11 of mechanics?

12 COMMISSIONER FIRESTONE: As a matter of
13 a comprehensive plan with all costs covered through a
14 pre-payment arrangement.

15 DR. THOMSON: I think it can. I
16 would suggest that our attitude here is we are in favour
17 of a try to make a realistic or reasonable premium and we
18 feel under this basis that it is impossible. Certainly
19 there is no reason why these costs could not be covered
20 by some premium. This would be a matter of mechanics
21 which would have to be worked out within the insuring
22 agency whether it happens to be our plan or some other
23 insurance body.

24 COMMISSIONER FIRESTONE: Would you be
25 in favour of such a pre-payment plan if the extra medical
26 services did relate over the principle pre-payment all
27 across the board?

28 DR. THOMSON: I see nothing wrong with
29 that, it would be practical.

30 COMMISSIONER FIRESTONE: Thank you.



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2 from what you have been saying that you and your

3 associates are in favour of the pre-payment principle for

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23 in favour of such a pre-payment plan if the extra medical

24 services did relate over the principle pre-payment all

25 across the board?

26 DR. THOMSON: I see nothing wrong with

27 that, it would be practical.



1 Now I come to the second part of this
2 definition where you say: "Without major deterrents."
3 Now, you were very helpful to the Commission in answering
4 some of the questions that the Chairman has put to you
5 and you have covered most of the ground, but I would just
6 like to understand one or two points relating thereto.
7 You speak of "major deterrents"; would you consider in
8 case Alberta had a comprehensive pre-paid physician care
9 plan with a requirement for the patient to pay for his
10 first call a major deterrent?

11 DR. THOMSON: In Alberta we would
12 consider that a major deterrent.

13 COMMISSIONER FIRESTONE: And the reason
14 you feel he should not be asked to pay this fee for the
15 first call is in his own interests you do not want to
16 discourage patients seeing doctors when he feels he is in
17 need of medical advice or service?

18 DR. THOMSON: That is true.

19 COMMISSIONER FIRESTONE: So the first
20 reason why you will object to what is a major deterrent
21 is the interest of the patient and, secondly, I presume
22 you feel that in fact physicians would be subsidizing
23 such deterrent fees particularly in rural areas since he
24 may never collect.

25 DR. THOMSON: I am sorry, sir, I did
26 not say that. This has been indicated as a potential but
27 I would feel that the lack of major deterrents, I would
28 refer here to major deterrents or major things which might
29 prevent the patient from seeking necessary medical care.
30 This is what we mean by major deterrents to his seeking



1 necessary medical care.

2 COMMISSIONER FIRESTONE: So your
3 prime concern is that a deterrent is not in the interests
4 of a patient?

5 DR. THOMSON: That is right.

6 COMMISSIONER FIRESTONE: And that is
7 why you are against it?

8 DR. THOMSON: That is why we are
9 against it when this patient is responsible for his account.

10 COMMISSIONER FIRESTONE: Well, you
11 qualified it a little "when this patient is responsible
12 for his account". Let us assume we had a comprehensive
13 medical care plan in operation in the province of Alberta
14 on a voluntary basis such as you have recommended, but in
15 many cases the patient not being responsible for his
16 account because he is not in a financial position to pay,
17 would you still say you would not wish a major deterrent
18 to be applied?

19 DR. THOMSON: Yes, sir, we would feel
20 if the individual is not able to apply he should have and
21 he is the one who should have comprehensive coverage of
22 a service type more than any one else. We would still
23 not want deterrents placed in the way of individuals who
24 could not pay for his own insurance.

25 COMMISSIONER FIRESTONE: In other
26 words, you are against the system of major deterrents in
27 any comprehensive plan which is developed on a voluntary
28 basis?

29 DR. THOMSON: Yes, sir.

30 COMMISSIONER FIRESTONE: Now, if I



1 understand you correctly and, please correct me if my
2 understanding was not quite to the point, you made a
3 distinction between deterrent and co-insurance when you
4 were discussing with the Chairman this \$2.00 payment in
5 connection with the hospital programme. Was my under-
6 standing correct that you looked at this \$2.00 payment
7 as a co-insurance element and not as a deterrent?

8 DR. THOMSON: Yes, this happened to
9 be in different areas.

10 THE CHAIRMAN: In hospitalization?

11 DR. THOMSON: In hospitalization.

12 It has been our consideration of it, I am not sure of the
13 actual financial mechanics, but I think it might be
14 indicated that the \$2.00 per day is probably paying for
15 the usage which is really a co-insurance. The individual
16 is assisting and assuming some of his responsibilities
17 for the cost of his hospital care in that case. One
18 would feel that in certain instances where pre-payment
19 occurs for medical services the individual pays a part
20 and someone else may assist him in paying a part, but
21 he still has a responsibility there.

22 COMMISSIONER FIRESTONE: I take it
23 from what you are saying that you have no objection to
24 this amount, whatever the amount is, \$2.00 or \$1.50 or
25 less, as long as it serves a means of contributing to the
26 payment of the programme and as long as this amount is
27 not large enough to serve as a deterrent. Is that the
28 principle you are following?

29 DR. THOMSON: Yes, that is a good
30 statement of the situation.



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1 COMMISSIONER FIRESTONE: In other
2 words, you are in favour of co-insurance but when co-
3 insurance becomes so high that it will serve as a
4 deterrent then by that time you will say "No, this will
5 be a major deterrent, I would not be in favour of it."
6 Was my understanding correct?

7 DR. THOMSON: That is partly it
8 although the wording may leave the mildly wrong impression.
9 We are certainly in favour of an individual assuming
10 responsibilities and if co-insurance happens to be the
11 form of assuming responsibility then I think we would
12 say yes.

13 COMMISSIONER FIRESTONE: While we
14 are just discussing this federal-provincial hospitaliza-
15 tion programme, can you tell us whether your group has
16 been satisfied with the operations of the programme or
17 whether you have run into any difficulties which you
18 feel might usefully be corrected?

19 DR. THOMSON: I think in answer to
20 that, in the first instance I indicated earlier that the
21 hospitalization programme in Alberta is not greatly
22 different from what it was prior to the participation by
23 the federal government and it has been satisfactory; and
24 it has, by and large, been satisfactory. However, there
25 are definite areas in which the cost factors are giving
26 some concern and this has been making it difficult for
27 some of the hospital boards and bodies to operate the
28 hospitals readily and, shall I say, financially
29 successfully. Yes, there have been some areas of
30 difficulty there but, by and large, the programme has

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successfully. Yes, there have been some areas of

difficulty there but, by and large, the programme has



1 been a good one.

2 COMMISSIONER McCUTCHEON: Would you
3 be referring particularly to the teaching hospitals?

4 DR. THOMSON: Not necessarily,
5 although they are probably a more important area. I
6 understand that the main teaching hospital will be
7 presenting a brief to you with regard to their problems.
8 We have reference in the body of the brief to the fact
9 that under certain instances the provincial government
10 has granted a rise of three per cent in the costs of
11 the previous year. However, at the same time there are
12 other factors which have offset or tend to offset these
13 things which are beyond their control where certain
14 employees are granted a five per cent increase in their
15 wages. These factors vary and would indicate the lack
16 of fiscal economy in that area makes it difficult for
17 the members of the hospital board to operate financially
18 successfully.

19 DR. GRISDALE: I think we should
20 mention that this hospitalization scheme as it is in
21 effect at the present time has been in effect for a
22 short enough period of time so it still seems possible
23 to us there may be problems that will come up in the next
24 short while that have not yet arisen.

25 COMMISSIONER FIRESTONE: I was just
26 going to follow this up, thank you for making the point.
27 You mention that there are a number of areas where
28 difficulties exist and refer to the problem of costs and
29 financing. Would you care to elaborate more on those
30 problems?



1 DR. THOMSON: Well, we have simply
2 been made aware of this situation and I would feel that
3 you probably would have more expert and definitive views
4 presented from the Hospital Association or from the main
5 teaching hospital of the University of Alberta. I do not
6 believe it was raised with the Department of Public Health
7 itself, but this is the feature which has been known to
8 us and we are aware of the concern of the hospital boards
9 in this regard.

10 COMMISSIONER FIRESTONE: Well now, as
11 you appreciate, Dr. Thomson, we will, of course, direct
12 these questions to the hospital administrators and other
13 groups that are involved, but here we have the medical
14 profession of Alberta and we would like to have your views
15 as to how the problems which the hospitals are facing
16 under the programme and affecting your ability to provide
17 the best possible services to your patients. As doctors
18 you must have run into some problems and we would like
19 your views of the problems. We can follow them up with
20 the hospitals themselves; but we would like to have a
21 rounded opinion from both the suppliers of the services
22 and the users of the services; you are the user by
23 arranging to have the services used by your patients.
24 We would like your help but we are not interested in a
25 quick answer. If you feel this matter is important
26 enough that you wish to give further consideration to it
27 and let us have your views and that of your associates
28 in writing at a later stage, we will be very happy to
29 have your views at such a time you feel appropriate.

30 DR. THOMSON: Well, if such were the



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you appreciate, Dr. Thomson, we will, of course, direct those questions to the hospital administrators and other groups that are involved, but here we have the medical profession of Alberta and we would like to have your views as to how the problems which the hospitals are facing under the program are being met; an ability to provide the best possible services to your patients. As doctors you must have run into some problems and we would like your views of the problems. We can follow them up with the hospitals themselves, but we would like to have a rounded opinion from both the suppliers of the services and the users of the services; you are the user by wanting to have the services used by your patients. We would like your help but we are not interested in a quick answer. If you feel this matter is important enough that you wish to give further consideration to it and let us have your views and that of your associates in writing at a later stage, we will be very happy to have your views at such a time you feel appropriate.

DR. THOMSON: Well, if such were the



1 agreement of the Commission, I feel that this might be
2 well worth while because we have indicated that while
3 the programme has been recently new, changes have been
4 minor up to the present time, it has not seriously or
5 greatly interfered with our care of patients. However,
6 we do recognize areas particularly where there is a
7 feeling of costs where the additional service which might
8 be available within that hospital could become inter-
9 fered with. We have given consideration to that,
10 considerable consideration I might say, but we have not
11 had any definitive or definite argument against or
12 corrective in this sense. We would be prepared and
13 happy to give you our thoughts on a separate submission
14 if you so desire.

15 THE CHAIRMAN: If you will.

16 COMMISSIONER BALTZAN: Is there a
17 clue or some study which would show the percentage of
18 patients who require or demand special services as
19 against the estimates of your total cost for so-called
20 comprehensive medical services?

21 DR. THOMSON: This may be obtained
22 if you have a certain group of people, first, under the
23 old age assistance group, the figures could be made
24 available and also under the Medical Services Incorporated
25 who have a half a million people on their roles.
26 This may be done. I am sorry I cannot give it to you
27 right now.

28 COMMISSIONER BALTZAN: I do not
29 require it at the present time. I am reading up to
30 this: perhaps from that one could get an estimate of



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THE CHAIRMAN: If you will.

GOVERNOR JAMES H. HARRIS: Is there a

line on some body which would show the percentage of patients who require or demand special services as against the estimates of your total cost for so-called comprehensive medical services?

MR. THOMSON: This may be obtained if you have a certain group of people, first, under the old age assistance group, the figures could be made available and also under the Medical Services Insurance Act who have a half a million people on their rolls. This may be done. I am sorry I cannot give it to you right now.

GOVERNOR JAMES HARRIS: I do not

require it at the present time. I am needing up to this: perhaps from that one could get an estimate of



1 the so-called extra billing amounts in dollars.

2 DR. THOMSON: We have a fairly good
3 estimate of that. It is something around less than four
4 per cent.

5 COMMISSIONER BALTZAN: Perhaps you
6 could tie up this thing, that is why one type of
7 plan gives universal coverage and this extra billing
8 which requires another type of tariff.

9 DR. BRAMLEY-MOORE: Medical Services
10 Alberta Incorporated have made a study of the amount of
11 extra billing and I would feel they would be prepared to
12 give you some definite information in respect to the
13 amount of it. As Dr. Thomson indicated, that figure is
14 less than four per cent. Now, there are certain reasons
15 for that which perhaps might be enlarged upon a little
16 bit. Dr. Thomson mentioned the schedule of fees and the
17 schedule of fees while it is based on the principle of
18 one fee for one procedure, these procedures which are
19 normally only carried out by specialists are fixed at
20 the fee that the specialist normally charges so that any
21 extra billing in those areas would be where the patient
22 desired, you might say, the most popular individual for
23 which they are prepared to pay a little extra.

24 COMMISSIONER BALTZAN: In other words,
25 it is an extra charge, but not a super charge?

26 DR. BRAMLEY-MOORE: That is right.

27 COMMISSIONER FIRESTONE: Dr. Thomson,
28 I would like to express our appreciation for your
29 willingness to provide us with additional information.
30 Could you include in the supplementary brief three things

the so-called extra billing amounts in dollars.

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Could you include in the supplementary brief three things



1 First, a statement of the problem areas, secondly, the
2 reason why it is a problem, and thirdly, what, in your
3 opinion, in your associates', can be done about it?

4 DR. THOMSON: Yes, sir, we would be
5 happy to.

6 COMMISSIONER FIRESTONE: May I
7 continue on this little discussion about the hospitaliza-
8 tion programme as it operates in Alberta. Have you or
9 your associates come across any indications of over-
10 utilization of hospital facilities as a result of that
11 programme?

12 DR. THOMSON: It is very difficult,
13 Dr. Firestone, to be accurate on this, but there is an
14 impression that there is utilization as a result of this
15 programme in that people tend or want to stay longer.
16 There are many people who want or desire to go into
17 hospital, even though their acute illness may not be of
18 sufficient severity to ordinarily warrant that. There
19 is a trend toward the utilization of these beds as a
20 result of that programme. I think it is fair to say that,
21 since the programme was introduced, anyway.

22 COMMISSIONER FIRESTONE: Well now,
23 sir, how is this trend being handled?

24 DR. THOMSON: On the part of the
25 profession we have established within our hospitals
26 admission and discharge committees that are established
27 within the hospital on the part of the medical staff,
28 continuing review boards which attempt, in the first
29 instance, to note whether active hospital treatment is
30 necessary or not, and to facilitate their discharge.



First, a statement of the problem areas; secondly, the reason why it is a problem, and thirdly, what, in your opinion, in your association, can be done about it?

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COMMISSIONER WINESTONE: Well now,

DR. THOMSON: On the part of the

profession we have established within our hospitals admission and discharge committees that are established within the hospital on the part of the medical staff, continuing review forces which attempt, in the first instance, to note whether active hospital treatment is necessary or not, and to facilitate their discharge.



1 I think that this is the only thing which can be done
2 so far as what might be called over-utilization is
3 concerned, in other words, unnecessary use of the beds.
4 It would be means of doctor and patient education with
5 admission and discharge committees and groups who try
6 to facilitate their removal, and probably to influence
7 their admission to hospitals.

8 COMMISSIONER FIRESTONE: Sir, what
9 happens if this board finds one or the other physician
10 as a rule sends more patients to use active treatment beds
11 than the profession as a whole, on the average. Would
12 this be drawn to his attention and he be asked to mend
13 his ways or asked for an explanation? How does it work
14 in practice?

15 DR. THOMSON: In practice, sir, this
16 fact of admission doesn't come out that way at all. A
17 person is sick to be admitted to hospital. It becomes
18 very difficult for some one else to say to another
19 doctor or another patient, you don't need to go to
20 hospital. Therefore, I think the majority of people who
21 are admitted are admitted because they are sick in one
22 way or the other, but their discharge can certainly be
23 facilitated, and this again is a matter of education and
24 co-operation on the part of doctors, patients and hospitals.

25 COMMISSIONER FIRESTONE: Dr. Thomson,
26 I certainly accept your statement the majority of people
27 go to hospital because they are sick. Nobody really likes
28 to go to hospital unless he has to. There is no question
29 about the majority. We are concerned here with perhaps
30 a number of cases that the physicians will send to



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1 hospitals that might have been treated, say, in out-
2 patient arrangements or some other arrangements, and this
3 raises the question, not of the majority, but of some
4 cases.

5 As you realize, sir, even some cases
6 may have an impact on the usage of hospital beds and my
7 question refers to those some cases rather than the
8 majority.

9 DR. THOMSON: I realize that, Dr.
10 Firestone, but I think the answer is, while this can
11 exist as over-utilization, there is not much -- our
12 greater concern is rather with the retention in active
13 treatment beds of individuals who can be treated else-
14 where. We feel that we can alleviate this situation and
15 we will be in a better position to leave the active
16 treatment bed available for the persons who need it.
17 Perhaps Dr. Grisdale would have some specific information
18 on that.

19 DR. GRISDALE: I think in direct
20 answer to your question as to control of the admissions,
21 this is done in certain hospitals in the province whereby
22 admissions are reviewed and those that are considered to
23 not be of emergent nature, one need not be admitted
24 today in preference to somebody else were handled and
25 those that the committee feels are unfair to the rest
26 of the sick population, are brought up with the
27 admitting physician and discussion is held with him.

28 If it is happening on more than a
29 reasonable number of occasions, the physician can be
30 dealt with by the hospital board and his privileges can



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2 patient arrangements or some other arrangements, and this
3 raises the question, not of the majority, but of some
4 cases.
5 As you realize, sir, even some cases
6 may have an impact on the usage of hospital beds and my
7 question refers to those some cases rather than the
8 majority.

9 DR. THOMSON: I realize that, Dr.
10 Wrestone, but I think the answer is, while this can
11 exist an over-utilization, there is not much -- our
12 greater concern is rather with the retention in active
13 treatment beds of individuals who can be treated else-
14 where. We feel that we can alleviate this situation and
15 we will be in a better position to leave the active
16 treatment bed available for the persons who need it.
17 Perhaps Dr. Grisdale would have some specific information
18 on that.

19 DR. GRIDALE: I think in direct
20 answer to your question as to control of the admissions,
21 this is done in certain hospitals in the province whereby
22 admissions are reviewed and those that are considered to
23 not be of urgent nature, are not be admitted
24 today in preference to somebody else were handled and
25 those that the committee feels are unfair to the rest
26 of the sick population, are brought up with the
27 admitting physician and discussion is held with him.
28 If it is happening on more than a
29 reasonable number of occasions, the physician can be
30 dealt with by the hospital board and his privileges can



1 be stopped, and are stopped at times.

2 COMMISSIONER FIRESTONE: This review
3 procedure that you were suggesting is applicable to some
4 hospitals?

5 DR. GRISDALE: I think it depends
6 more than anything else probably on the number of beds
7 that are available in the locality, and if the bed
8 situation is very short, I think that the procedure is
9 more strigent and more active than it is if the bed
10 situation is very good, so to speak.

11 COMMISSIONER FIRESTONE: I take it
12 there are a number of hospitals without review procedures?

13 DR. GRISDALE: Yes, there are
14 hospitals without review procedures.

15 COMMISSIONER FIRESTONE: I take it
16 from that there may be many that don't have a review
17 procedure. There may be over-utilization because the
18 procedure hasn't been reviewed. They don't know.

19 DR. GRISDALE: I am sure that is
20 true. I think the utilization of the hospitals that you
21 are talking about varies tremendously depending upon the
22 number of hospital beds.

23 In Calgary there is a situation whereby
24 care is asked unless it is a really dire emergency.

25 In Edmonton where we have a reasonably adequate number of
26 beds per thousand population the person doesn't need to
27 be nearly as sick to be admitted. I think that is a
28 true statement. There are two Calgary doctors here who
29 might amplify that, Dr. Dixon and Dr. Woolstencroft.

30 DR. WOOLSTENCROFT: That is true,

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might apply that, Dr. Dixon and Dr. Woolstenhorne.

DR. WOOLSTENHORNE: That is true.



1 depending upon the number of beds available, the question
2 of admittance becomes paramount, and in a tight situation,
3 the authority of the profession is brought into play to
4 control this situation. I agree with Dr. Grisdale,
5 where there are more beds you may get less sick people
6 at the hospital.

7 I would add one further thing, that there
8 is an increasing self-discipline, I think, in the
9 profession imposed on one in these tight situations
10 where you have to resist the desire of the patient for
11 admittance to hospital when it is not merited more than
12 in other situations. It is obvious, but it is happening,
13 I think, more and more you have to practice that
14 discrimination in the practice.

15 DR. THOMPSON: I would believe part of
16 this problem was created by government saying it is the
17 right of every citizen in Canada, and if the beds are
18 empty the people cannot understand why they should be
19 not permitted to use their rights.

20 COMMISSIONER FIRESTONE: The main
21 problems is where bed use is tight, where as a result
22 of over-utilization, I am not saying it necessarily is
23 the case, as a result of possible over-utilization, the
24 pressure to build more hospitals increases and, therefore,
25 if one had adequate review procedures all across the
26 country some of that pressure might be reduced.

27 My question to you, Dr. Thomson, is
28 it in the interest of the medical profession in the
29 province of Alberta to make sure that this review
30 procedure exists so there will be reasonable use made of



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28 it in the interest of the medical profession in the
29 province of Alberta to make sure that this review
30 procedure exists so there will be reasonable use made of



1 the existing hospital bed facilities?

2 DR. THOMSON: I believe, Mr.

3 Firestone, they do exist. It depends, really on the
4 acuteness of the situation how aggressive or active the
5 committee is.

6 COMMISSIONER BALTZAN: And the size
7 of the hospital. Would you say all the major hospitals
8 definitely have these committees?

9 DR. THOMSON: Yes.

10 COMMISSIONER BALTZAN: In the places
11 these committees don't exist, would you say they are in
12 places where hospitals are too small for departmentaliza-
13 tion?

14 DR. THOMSON: They tend to be, Dr.
15 Baltzan, in the rural areas.

16 COMMISSIONER FIRESTONE: Dr. Thomson,
17 if I may come back to the point, am I right in under-
18 standing that these review procedures exist in all
19 hospitals in the province of Alberta?

20 DR. THOMPSON: The Minister of
21 Health has approved regulations relating to medical staff
22 organizations. These regulations were agreed to by the
23 associated hospitals of Alberta, by our organization,
24 and in order to be an approved hospital, the hospitals
25 must have such a committee, so I think we can state that
26 all hospitals are required to have that committee, but
27 as has been indicated, the actual operation of the
28 committee varies from place to place.

29 COMMISSIONER FIRESTONE: Do I under-
30 stand you have some information?



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COMMISSIONER FALTMAN: Do I under-

stand you have some information?



- 1 DR. McPHERSON: Thank you, Mr.
- 2 Firestone. I wanted to recall attention to the statement
- 3 made by Dr. Ross here yesterday about the manner in which
- 4 bed rated capacity is paid for from the provincial funds.
- 5 In our very many fine community hospitals
- 6 of twenty-five beds where they may be operating at fifty
- 7 per cent of capacity, they are still being paid on the
- 8 basis of their rated capacity. It then becomes rather
- 9 questionable whether we should say the services are being
- 10 over-utilized in that area if the patient is kept in an
- 11 extra day or two. The service is paid for and available.
- 12 COMMISSIONER FIRESTONE: That is a
- 13 very helpful observation, sir. It points out the problem
- 14 is really in those hospitals where the hospital bed
- 15 situation is tight.
- 16 DR. McPHERSON: Acute.
- 17 COMMISSIONER FIRESTONE: Therefore
- 18 my question, I might put it again to you, Dr. Thomson,
- 19 and your associates, with the fact that the review
- 20 procedure exists, is it not in the interest of the medical
- 21 profession to make sure these review procedures are used
- 22 effectively, not only at the end but at the beginning to
- 23 relieve that tight situation? You can relieve it at
- 24 both sides, at the beginning and the end.
- 25 DR. THOMSON: Yes.
- 26 COMMISSIONER FIRESTONE: If so, what
- 27 again do you think you, the medical profession, the
- 28 Medical Association of Alberta can do to make sure this
- 29 procedure, in fact, is applied? It isn't enough to have
- 30 a committee, you have to put that committee to work.



DR. McBRIDE: Thank you, Mr.

Firststone. I wanted to recall attention to the statement made by Dr. Ross here yesterday about the manner in which bed rated capacity is paid for from the provincial funds.

In our very many fine community hospitals of twenty-five beds where they may be operating at fifty

questionable whether we should say the services are being over-utilized in that case if the patient is kept in an extra day or two. The service is paid for and satisfied.

COMMISSIONER FIRSTSTONE: That is a very helpful observation, sir. It points out the problem is really in those hospitals where the hospital bed situation is tight.

my question, I might put it again to you, Dr. Thompson, and your associates, with the fact that the review procedure exists, is it not in the interest of the medical profession to make sure these review procedures are used effectively, not only at the end but at the beginning to relieve that tight situation? You can relieve it at both sides, at the beginning and the end.

COMMISSIONER FIRSTSTONE: If so, what again do you think you, the medical profession, the Medical Association of Alberta can do to make sure that procedure, in fact, is applied? It isn't enough to have a committee, you have to put that committee to work.



1 DR. THOMSON: Again, the action by
2 us as a profession is probably self-imposed, and it
3 revolves upon various members of the staff of the
4 hospitals to do this work. We don't send out a directive,
5 shall I say, through the College or the Medical
6 Association, that its members have assumed the respon-
7 sibility and I think all we can do, as I suggested to you,
8 sir, in most instances they will try to carry out the
9 responsibility. We agree with you that every effort
10 should be maintained, and it is a constance plea on the
11 part of Association for all its members to maintain that.

12 DR. WOOLSTENCROFT: Mr. Chairman,
13 I think if you require assurance on this matter there is
14 only one area in Alberta where there is an acute bed
15 shortage, and that is Calgary. I assure you the doctors
16 there don't require directives. They have their
17 committees and if you wish, the mechanics are fairly
18 simply. Cases are divided up into urgent, emergent and
19 elective, and there is a system whereby these are
20 repeatedly reviewed, and it is possible to assess from
21 day to day.

22 The question of emergency, emergent
23 admissions and elective ones, one has to state why one
24 is admitting a patient. This acts in the interests of
25 relieving the possible over-utilization.

26 COMMISSIONER FIRESTONE: In other
27 words, you are relying on self-discipline on the
28 attending physicians?

29 DR. WOOLSTENCROFT: Yes, sir, by the
30 the staff.

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words, you are relying on self-discipline on the

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DR. WOOLSTENHOLME: Yes, sir, by

and staff.



1 COMMISSIONER FIRESTONE: By the
2 staff. Do you review, in Calgary, how this works out
3 in practice? Do you find on occasion there may be some
4 physician that may be admitting many more cases than
5 the average, and if that happens, would somebody talk
6 to that physician?

7 DR. WOOLSTENCROFT: Yes, sir. Of
8 course, you can't base it on number of cases. It is the
9 type of cases.

10 COMMISSIONER FIRESTONE: We will
11 accept that.

12 DR. WOOLSTENCROFT: It is brought
13 in no uncertain terms to the doctor concerned, and I
14 assure you it has been very efficacious.

15 COMMISSIONER FIRESTONE: In other
16 words, if I may sum up the sense of the answers I have
17 received, the medical profession together with the
18 hospital administration are doing everything possible to
19 keep over-utilization to a minimum, and if there is an
20 increased demand for hospital beds, say, in Calgary,,
21 it is because you are using your hospital facilities to
22 the full. Am I right in this?

23 DR. THOMSON: I think that is
24 correct.

25 COMMISSIONER FIRESTONE: Thank you
26 very much, it has been most helpful. May I come back to
27 the question of pre-payment.

28 We have covered the question of the
29 hospitalization programme here in Alberta which is to
30 some extent pre-paid, to some extent because the \$1.50



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very much, it has been most helpful. May I come back to
the question of pre-payment.
We have covered the question of the
hospitalization programme here in Alberta which is to
some extent pre-paid, to some extent because the \$1.50



1 or the \$2.00 fee which is paid as you occupy the bed
2 and isn't pre-payment. It is perhaps a payment after
3 the services have been rendered, but there are certain
4 pre-payment features because of some of the contributions
5 being collected in taxes preceding to the illness of
6 the person.

7 Well now, we come to other aspects of
8 pre-payment. I understand you are in favour of a pre-
9 paid medical care plan for the province of Alberta on a
10 voluntary basis.

11 DR. THOMSON: Yes, sir.

12 COMMISSIONER FIRESTONE: Are you
13 also in favour of a pre-paid drug plan on a voluntary
14 basis?

15 DR. THOMSON: We haven't given it
16 any particular thought in developing it, but insofar
17 as pre-payment is a reasonable method of meeting expected
18 and unexpected costs of certain things, pre-payment for
19 drugs would seem to be -- I was going to say -- seem to
20 be reasonable, but the whole situation is so complex,
21 I am not quite sure how this would work on an insurance
22 basis, but nevertheless, if the principle of pre-payment
23 could be applied to the costs, expected and unexpected,
24 of drugs with reasonable premiums, then I would feel
25 that is worth while.

26 COMMISSIONER McCUTCHEON: How do you
27 feel about a deterrent under those circumstances?

28 DR. THOMSON: As far as we are
29 concerned with prescription drugs I don't think there need
30 be any deterrent.



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DR. THOMSON: As far as we are

concerned with prescription drugs I don't think there need
be any deterrent.



1 COMMISSIONER FIRESTONE: You feel
2 it should apply on drugs, drugs prescribed by the physician
3 as being essential, they should be covered?

4 DR. THOMSON: If you pay an insurance
5 premium this would cover the cost of prescription drugs,
6 yes, sir.

7 COMMISSIONER FIRESTONE: Thank you,
8 sir. If we could come to the question of financing of a
9 medical pre-payment care plan for the province of Alberta.

10 You have suggested in your brief that
11 67.5 per cent of the people of the province of Alberta
12 are covered by various schemes, various plans.

13 DR. THOMSON: Yes, sir.

14 COMMISSIONER FIRESTONE: That
15 includes the M.S.I., the commercial plans, and the social
16 service plans.

17 DR. THOMSON: Yes.

3 18 COMMISSIONER FIRESTONE: And there
19 are 32.5 per cent without medical care, without pre-paid,
20 without being covered by a pre-paid medical care programme
21 of one kind or another?

22 DR. THOMSON: Yes, sir.

23 COMMISSIONER FIRESTONE: Now, sir,
24 the 67.5 per cent that are covered, would you say that
25 all the people in that group are covered adequately?

26 DR. THOMSON: No, they are not.

27 COMMISSIONER FIRESTONE: Adequately,
28 using the definition which you give yourself in paragraph
29 56?

30 DR. THOMSON: No, they are not all



Thomson

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of one kind or another?

DR. THOMSON: Yes, sir.

COMMISSIONER: SECOND QUESTION: Now, sir,

the 0.5 per cent that are covered, would you say that

all the people in that group are covered adequately?

DR. THOMSON: No, they are not.

Adequately.

Using the definition which you give yourself in paragraph

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DR. THOMSON: No, they are not all.



1 adequately covered according to this comprehensive plan.
2 COMMISSIONER FIRESTONE: Would you be
3 able to elaborate what proportion of the 67.5 per cent
4 are, in your opinion, not adequately covered, and if
5 this information is not available, could you please take
6 it under advisement, and let us have your answer at a
7 later date?

8 DR. THOMSON: This material is
9 available, sir, in our exhibit with regards to survey.

10 COMMISSIONER FIRESTONE: Then please,
11 would you just deal with the question for the way you
12 consider appropriate, sir?

13 DR. THOMSON: We have a rapid break-
14 down which might show all of that. I remember all of
15 the households, which is not individuals, of all the
16 households, 53.4 per cent might be considered as
17 comprehensively covered; 14.1 per cent as partially.

18 COMMISSIONER FIRESTONE: Well, sir,
19 as I recall this figure refers to household. The figure
20 in the report refers to 67.5 per cent of the population?

21 DR. THOMSON: This is true, and this
22 has been broken down by the method of transferring
23 households to population.

24 COMMISSIONER FIRESTONE: I am just
25 asking a simple question. You say 67.5 per cent, which
26 you say are covered -- what proportion is adequate,
27 using your definition, sir?

28 DR. THOMSON: According to our
29 adequate coverage, I could not transpose that to individuals
30 for you very rapidly, sir, but if it is 53.4 per cent of



1 the households, in that particular level it is a little
2 bit higher, and is certainly over half of the population.

3 COMMISSIONER FIRESTONE: Well, I do
4 not want to discuss with you statistics. I would be
5 happier if this material would be considered, because you
6 realize, of course, there are a lot of individual persons
7 who are not members of households and that may bring the
8 figure down. But I do not want to get involved in a
9 discussion of statistics. I just want to establish that
10 what you are speaking of, 67.5 per cent, really covers
11 coverage of all kinds, some of which is not adequately
12 covered?

13 DR. THOMSON: That is true.

14 COMMISSIONER FIRESTONE: Can we, for
15 discussion, and just for approximate discussion, assume
16 that about half of the population is, according to your
17 definition, adequately covered, and the other is either
18 inadequately covered or not covered at all. Can we use
19 that for a basis of discussion, and we stand subject to
20 correction in any subsequent information you wish to put
21 before us?

22 DR. THOMSON: We can use that as an
23 assumption for a basis of discussion.

24 COMMISSIONER FIRESTONE: As an
25 approximate and reasonable figure?

26 DR. THOMSON: Yes.

27 COMMISSIONER FIRESTONE: Now, sir,
28 the fifty per cent you feel are adequately covered would
29 include people that are covered by M.S.I?

30 DR. THOMSON: And by other insuring



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DR. THOMSON: Yes.

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DR. THOMSON: And by other financing



1 agencies.

2 COMMISSIONER FIRESTONE: And other
3 commercial carriers?

4 DR. THOMSON: Yes.

5 COMMISSIONER FIRESTONE: Now, these
6 people are covered because they pay a premium?

7 DR. THOMSON: Yes, sir, or the
8 premium is paid for them.

9 COMMISSIONER FIRESTONE: For them in
10 social services cases by the government?

11 DR. THOMSON: Yes, sir.

12 COMMISSIONER FIRESTONE: That is
13 correct, sir.

14 Now, what happens, sir, if somebody
15 becomes unemployed or suffers protracted illness and
16 cannot pay his premium?

17 Now, this person might have been a
18 carpenter who has had a good job; he is not a social
19 service case; he has not saved very much money, and he
20 cannot pay the premiums. What happens to him?

21 DR. THOMSON: The Medical Services of
22 Alberta Incorporated continue to carry that individual
23 during the period of his sickness.

24 COMMISSIONER FIRESTONE: Even though
25 he does not pay any premium?

26 DR. THOMSON: This is correct.

27 COMMISSIONER FIRESTONE: Even though
28 he may last a year -- some times this chronic or serious
29 illness may take six months or more?

30 DR. THOMSON: They are paying his



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1 account. They will cover him during the period of his
2 illness.

3 Various discussions are being held
4 with regards to this, but in many of the forms of
5 insurance you do not pay your premium while you are sick.
6 I do not think I can go further than that, that these are
7 covered. The studies are under way as to how these
8 people might be continued not only during periods of
9 sickness but during periods of unemployment, up to a
10 certain period of time, at least.

11 COMMISSIONER FIRESTONE: But you
12 would say that in the fifty per cent that you consider
13 as being adequately covered you would include what has
14 been described to us as the medically indigent people
15 that can afford to pay for their medical service or
16 pre-payment service while they are employed or while,
17 because of loss of job or because of sickness, they be-
18 come medically indigent, and there are fifty per cent in
19 the category of people of that type?

20 DR. THOMSON: There are some, but
21 in that fifty per cent who are adequately covered, we
22 recognize again there are the allowance for social
23 assistance group, and these are normally indigents, who
24 under the means test are securing assistance, and they
25 are comprehensively covered.

26 COMMISSIONER FIRESTONE: But that is
27 a smaller proportion?

28 DR. THOMSON: That is a smaller
29 proportion, but they are covered. And in that group who
30 are not covered --- in that fifty per cent --- there



Various discussions are being held

with regards to this, but in many of the forms of

insurance you do not pay your premium while you are sick.

I do not think I can go further than that, that there are

covered. The studies are under way as to how these

people might be continued not only during periods of

sickness but during periods of unemployment, up to a

certain period of time, at least.

COMMISSIONER FIRESTONE: But you

would say that in the fifty per cent that you consider

as being adequately covered you would include what has

been described to us as the medically indigent people

that can afford to pay for their medical service or

pre-payment service while they are employed or while,

because of loss of job or because of sickness, they be-

come medically indigent, and there are fifty per cent in

the category of people of that type?

DR. FRIEDMAN: There are some, but

in that fifty per cent who are adequately covered, we

recognize again there are the allowance for social

assistance group, and these are normally indigent, who

under the means test are receiving assistance, and they

are comprehensively covered.

COMMISSIONER FIRESTONE: But that is

a smaller proportion?

DR. FRIEDMAN: That is a smaller

proportion, but they are covered. And in that group who

are not covered --- in that fifty per cent --- there



1 are a number of people who, for various reasons other
2 than inadequate means, are not covered. They may not
3 like pre-payment insurance; they may have other methods
4 of looking after it. Many of them are indifferent.
5 I am not trying to enlarge the group. I am simply saying
6 there are some people within that group who cannot afford
7 to pay. We have also figures which would indicate that
8 in that group who do not have any coverage there is a
9 very wide range of capability of insurance.

10 COMMISSIONER FIRESTONE: Well, I
11 understand, Dr. Thomson, your comment in particular
12 related to the second group, the people who are not
13 covered or adequately covered.

14 My question is just concentrated on the
15 first fifty per cent, the fifty per cent you consider to
16 be adequately covered, and I understand you would say
17 there are included in that fifty per cent a number of
18 people who are described as medically indigent?

19 DR. THOMSON: That is correct, yes,
20 sir.

21 COMMISSIONER FIRESTONE: So that one
22 can then conclude that even though there is a fifty per
23 cent coverage somewhat less than half the people are
24 assured of continuity of medical care services which they
25 paid for because, when they become medically indigent
26 and they are not of two categories ---- social service or
27 M.S.I. ---- in case of sickness, and they stop making
28 payments, they will then not be able to get the services.

29 Take, for example, somebody that has
30 M.S.I. He becomes unemployed; he cannot pay the premium,



than inadequate means, are not covered. They may not like pre-payment insurance; they may have other methods of looking after it. Many of them are indifferent. I am not trying to enlarge the group. I am simply saying there are some people within that group who cannot afford to pay. We have also figures which would indicate that in that group who do not have any coverage there is a very wide range of capability of insurance.

COMMISSIONER FIRSTONE: Well, I

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DR. THOMSON: That is correct, yes.

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M.S.I. He becomes unemployed; he cannot pay the premium.



1 and he will then get sick; he has not paid the premium
2 and, therefore, he just has to find the money to pay his
3 medical bill?

4 DR. THOMSON: He does not have M.S.I.?

5 COMMISSIONER FIRESTONE: He has M.S.I.

6 DR. THOMSON: He has M.S.I., yes.

7 COMMISSIONER FIRESTONE: He becomes
8 unemployed and cannot pay the premium.

9 DR. THOMSON: Yes?

10 COMMISSIONER FIRESTONE: Then, two
11 months later he takes sick.

12 DR. THOMSON: Yes?

13 COMMISSIONER FIRESTONE: He is not
14 entitled to receive the services and have them paid for
15 by M.S.I. if he has not paid his premium?

16 DR. THOMSON: If he has not paid
17 his premium, I believe this is correct. I have not got
18 it from M.S.I., but I would believe that is so.

19 COMMISSIONER FIRESTONE: We would be
20 very happy to have that confirmed from M.S.I., but
21 assuming this is so, that we have fifty per cent including
22 the medically indigent, and the conclusion that we come
23 to is that we do not have really in the province of
24 Alberta the majority of people covered by medical care
25 services on a comprehensive basis as you defined it in
26 your paragraph 56 on a continuing basis, because there
27 are interruptions in income because of unemployment,
28 sickness, crop failures, and so on.

29 Is this a reasonable conclusion in the
30 light of the information which you have supplied?



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the medically indigent, and the conclusion that we come
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Alberta the majority of people covered by medical care
services on a comprehensive basis as you defined it in
your paragraph 50 on a continuing basis, because there
are interruptions in income because of unemployment,
sickness, crop failures, and so on.

Is this a reasonable conclusion in the
light of the information which you have supplied?



1 DR. THOMSON: That the fifty per cent
2 of them are not covered?

3 COMMISSIONER FIRESTONE: Or less than
4 fifty per cent --- even fifty per cent are adequately
5 covered?

6 DR. THOMSON: Less than fifty per
7 cent of them are not covered, yes. I think that is a
8 fair assumption.

9 COMMISSIONER McCUTCHEON: I suppose
10 there would be people moving from the non-covered group
11 to the covered group, so that your sample might be taken
12 to be active on the average at any time?

13 DR. THOMSON: Yes, I think this
14 would be so.

15 THE CHAIRMAN: You could probably
16 contact M.S.I. and they will have the figures as to how
17 many people drop out in any given period because of
18 failure to pay premiums for whatever reason.

19 DR. GRISDALE: Only one comment I
20 would like to make. A minute ago you said --- you changed
21 it later, but a minute ago you said that these people
22 would not get the service. This, of course, is not true.
23 Whether they have the coverage or not, they will
24 certainly get the service and do always.

25 COMMISSIONER FIRESTONE: But the
26 service will then not be paid for out of the pre-paid
27 plan?

28 DR. GRISDALE: Out of the pre-paid
29 plan, no.

30 COMMISSIONER FIRESTONE: And the



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COMMISSIONER THORNTON: But the

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DR. THORNTON: One of the pre-paid

COMMISSIONER THORNTON: And the



1 person who has become unemployed ---- the person who is
2 in the weakest position to pay will then be required to
3 pay; is that not correct?

4 DR. GRISDALE: Yes, partially it is
5 correct, in that he would have a debt, so to speak.

6 COMMISSIONER FIRESTONE: That is
7 right.

8 DR. GRISDALE: However, I am sure in
9 medicine in all of Canada, and certainly it is true in
10 Alberta that if it is obvious that the person has not
11 got the resources to meet his debts, the debt, in almost
12 all cases, is cancelled.

13 COMMISSIONER BALTZAN: Is that what
14 you mean in paragraph 6, that Alberta survey found that
15 only two per cent of all households and 3.1 per cent of
16 households with no coverage did not call a doctor
17 because they felt they could not afford it?

18 If you are to listen to the statistics
19 on only fifty per cent are adequately covered, you think
20 that the rest of the people are being neglected or have
21 not got the availability of medical care. Here you
22 break down by your statistics to almost a minimum of
23 two per cent.

24 DR. THOMSON: This is true that we
25 did not receive information --- we did not receive in-
26 formation that people were unable to get medical
27 attention because they could not afford it, and in this
28 survey it was less than two per cent that did not call
29 the doctor because they felt they could not afford it.

30 COMMISSIONER FIRESTONE: What we are



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in the weakest position to pay will then be required to
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DR. GRIFFITHS: Yes, partially it is
correct, in that he would have a debt, so to speak.
COMMISSIONER WESTON: That is

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DR. GRIFFITHS: However, I am sure in
medicine in all of Canada, and certainly in this
Alberta that it is obvious that the person who
got the resources to meet his debts, the debt, in almost
all cases, is cancelled.

COMMISSIONER WESTON: Is that what
you mean in paragraph 6, that Alberta survey found that
only two per cent of all households are 3 or 4 per cent of
households with no coverage did not call a doctor
because they felt they could not afford it?

If you are so limited to the statistics
on only fifty per cent are adequately covered, you think
that the rest of the people are being neglected or have
not got the availability of medical care. Have you
break down by your statistics to show a minimum of
two per cent

DR. THOMSON: That is true that we
did not receive information --- we did not receive in-
formation that people were unable to get medical
attention because they could not afford it, and in this
survey it was less than two per cent that did not call
the doctor because they felt they could not afford it.

COMMISSIONER WESTON: What we are



1 discussing, sir, is --- we know that the medical profession
2 looks after the people in Alberta well, and that the
3 people get the services. It is not a question they are
4 not being looked after. We know you are looking after
5 them, and you are doing a first-class job in looking
6 after them, but the question before us is what happens
7 to pay for such services.

8 You suggested that if the fellow cannot
9 pay because he is unemployed, or through protracted
10 illness, and the pre-payment plan is not paying his shot,
11 in many cases the doctor will write off the indebtedness?

12 Is that the point you are making?

13 DR. GRISDALE: Yes.

14 COMMISSIONER FIRESTONE: You are
15 saying it is really the physician who is subsidizing the
16 medical care services in the province of Alberta?

17 DR. GRISDALE: The physicians
18 subsidize the care of indigent people in Alberta if need
19 be.

20 COMMISSIONER FIRESTONE: But you say,
21 sir, and we are talking of the medically indigent ---
22 these are the people under social service; these are
23 people who can afford to pay for themselves. How can a
24 fellow help it if he has not the savings, if he loses
25 his job, or has a crop failure and he becomes ill. He
26 has not the money to pay the doctor, unless the doctor,
27 out of the kindness of his heart, writes off the debt?

28 DR. GRISDALE: Yes.

29 THE CHAIRMAN: Then, we would have
30 to abolish all premium forms of government.



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looks after the people in Alberta well, and that the
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pay because he is unemployed, or through protracted
illness, and the pre-payment plan is not paying his share,
in many cases the doctor will write off the indebtedness.
Is that the point you are making?

COMMISSIONER WILKINSON: You are
saying it is really the physician who is subsidizing the
medical care services in the province of Alberta?
I am assuming that the people in Alberta need
subsidize the care of indigent people in Alberta if need
be.

COMMISSIONER WILKINSON: Not for pay,
sir, and we are talking of the medically indigent --
these are the people under social services; these are
people who are allowed to pay for themselves. How can a
fellow help if he has not the savings, if he loses
his job, or has a crop failure and he becomes ill. He
has not the money to pay the doctor, unless the doctor
out of the kindness of his heart, writes off the debt?

MR. CHAIRMAN: Yes.
THE CHAIRMAN: Then, we would have
to abolish all premium forms of government.



1 DR. McPHERSON: This is a traditional
2 privilege of the profession if they so desire. To go
3 along with your thinking, there is one area of payment
4 from public funds that we have not discussed. We have
5 talked about social assistance group, and those persons
6 who have had the foresight to provide some form of
7 insurance, but the man who is temporarily unemployed and
8 finds he is not only medically indigent but, in many
9 instances, the man with a family becomes indigent in
10 other ways --- getting food and shelter for his family.
11 And in this instance the municipality takes over. One
12 of our cities in our province, as a matter of fact, has
13 entered into an arrangement with our physicians sponsored
14 plan whereby these persons are covered by the city under
15 M.S.I.

16 There is, as a consequence, a fair
17 number of people that are receiving aid in that area on
18 a temporary basis.

19 THE CHAIRMAN: We will adjourn now
20 for lunch.

21
22 --- Luncheon adjournment.

23

24

25

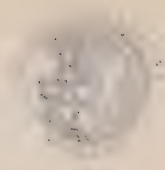
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THE CHAIRMAN: We will adjourn now

for lunch.

--- (unintelligible) ---



1

2 --- On resuming at 2,00 o'clock.

3

4 THE CHAIRMAN: Shall we continue?

5 COMMISSIONER FIRESTONE: Dr. Thomson,

6 just before lunch we had arrived at the position which

7 suggested that about half of the population of Alberta is

8 not covered or not adequately covered by a voluntary

9 pre-paid medical scheme according to the definition of

10 what you considered desirable. Another half is covered

11 adequately but this second half includes people who will

12 receive service, but if they cannot keep up their premium

13 payment, may be required to pay for such services. That

14 is, as I understand it, the sum total of our discussions

15 that took a little time to cover.

16 DR. THOMSON: Yes.

17 COMMISSIONER FIRESTONE: May I take

18 a little time as to what your views are as to the

19 possibilities of developing a plan for a comprehensive

20 medical care service in the province of Alberta that will

21 take care of these various groups which we have discussed?

22 As I understand it you and your colleagues have been

23 very helpful in making a number of comments, and if I

24 may restate my understanding of these comments; you

25 visualize such a plan to be (a) comprehensive and,

26 (b) voluntary and available to all the people of the

27 province?

28 DR. THOMSON: Yes, sir.

29 COMMISSIONER FIRESTONE: My next question

30 is: How can such a plan be financed? Where would the



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Just before lunch we had arrived at the position which suggested that about half of the population of Alberta is not covered or not adequately covered by a voluntary pre-paid medical scheme according to the definition of what you considered satisfactory. Another half is covered adequately but this second half includes people who will receive services, but if they cannot keep up their premium payment, may be required to pay for such services. That is, as I understand it, the main total of our discussion that took a little time to cover.

DR. THOMPSON: Yes.

COMMISSIONER: I understand that you have

a little time as to what your views are as to the possibility of developing a plan for a comprehensive medical care service in the province of Alberta that will take care of these various groups which we have discussed. As I understand it you and your colleagues have been very helpful in making a number of comments, and if I may venture my understanding of these comments, you visualize such a plan to be (a) comprehensive and (b) voluntary and available to all the people of the province?

DR. THOMPSON: Yes, sir.

12: How can such a plan be financed? Where would the



1 money come from to pay for it?

2 DR. THOMSON: Well, the profession
3 feels that the financing of such a programme is divided
4 into certain parts. Our first portion of this deals
5 with people who can afford to pay for the cost of their
6 medical care either by direct payment or through pre-
7 payment insurance. This we have determined, because we
8 lack a better standard, as those groups who pay income
9 tax. The federal government has decided that these
10 people have some discretionary income and we decided
11 then that those people who paid income tax should, in
12 essence, be responsible for their own payment or pre-
13 payment.

14 Secondly, there are a group of people
15 who are recognized as requiring full assistance and
16 support of government, and these are known as the social
17 assistance or allowance group. These people would be
18 paid for in the present arrangement in Alberta whereby
19 a subsidy on the part of the government pays for a large
20 part of their care and the profession, as they have
21 always traditionally, would like to assist in the care of
22 this group of people and they would not pay us for giving
23 them service. In other words, they would receive from
24 the schedule of fees a much lower recognized payment and
25 they would consider themselves adequately paid for this
26 group of people.

27 This leaves for us a group of people
28 between the recognized known group who are the assistance
29 group or allowance group and those who are capable of
30 paying income tax.



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1 We do not have accurate figures
2 as to the income tax, but we have been informed and
3 persuaded that the number of people who do not pay income
4 tax very closely approximates the figure which was used
5 in the survey and that is the people, the individuals
6 who made \$2,000.00 or less --- households who made
7 \$2,000.00 or less per annum. We have been able to
8 identify fairly closely the number of people who might then
9 fall in under the income tax level and above the social
10 assistance level. For that group
11 we have recommended that the provincial, by modification
12 or amendment of the provincial legislation, the provincial
13 government may be able to assist by subsidies, these
14 people in the payment of their pre-payment insurance.
15 By this means we feel that an individual would have the
16 right to take out insurance if he so desired or to pay
17 for it by whatsoever means he could if he was able to or
18 to refrain entirely if he happened to have any
19 antipathy towards any medical care payments on insurance.
20 Similarly those people who were between the income tax
21 level and the social assistance group would have the
22 right to apply for assistance if they felt that they needed
23 it, if they wanted to take out medical care insurance.
24 Under some system this would involve a means test, again,
25 but under the same system the provincial government might
26 be able to assist these people just as many of the companies
27 today assist many of their people in the payment of
28 their insurance. It is specifically applied to an area
29 who require the assistance, but if they need, and this
30 leaves a problem a personal responsibility for payment



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2 afford it. It very clearly delineates the areas of
3 responsibility and the recognition of the fact that
4 responsibility is probably a valuable asset in our
5 citizens for the assumption of responsibility is a valu-
6 able asset.

7 I think that this briefly covers it.

8 If you can accept certain premises, again, under the
9 amount allowed by the provincial government to the
10 College of Physicians and Surgeons, each individual and
11 social assistance group, that is \$24.00 per annum,
12 \$2.00 per month. We know that today it costs for the
13 covering of fifty-one thousand people \$1,224,000.00.
14 We know that there are a number of people who will qualify,
15 they are increasing each month, but we assume that there
16 are probably another nineteen thousand people who could
17 be covered under that. This would make around seventy
18 thousand individuals who might be covered under that
19 scheme. To cover them all on behalf of the provincial
20 government payment to the College of Physicians and
21 Surgeons and with participation of the doctors it would
22 cost the government \$450,000.00 per annum over and above
23 the \$1,224,000.00 which is now paid. This would indicate
24 a total cost for the social assistance group. For the
25 people who were paying income tax and paying for their
26 own, we will discard them for the moment.

27 For the remainder we realize from our
28 figures that there are approximately one hundred thousand
29 people who might -- we don't say they would but who
30 might be eligible for assistance. Now, if under the



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For the remainder we realize from our figures that there are approximately one hundred thousand people who might -- we don't say they would but who might be eligible for assistance. Now, if under the



1 rate of the Medical Services of Alberta Incorporated
2 which is estimated at about thirty thousand per annum
3 as covering people, if these people were covered, this
4 one hundred thousand, it would be \$3,000,000.00. This,
5 I submit, must be contrasted with the coverage of
6 1,300,000 people at \$30.00 per annum which would be
7 \$40,000,000.00 per year in the event these people are
8 checked or looked at or if they applied it is unlikely
9 they would all need total assistance. The provincial
10 government might give them total assistance in the pre-
11 payment but it is more likely they would subsidize and
12 we would feel they should subsidize by contributing to
13 the individual receiving assistance in that form and
14 receiving assistance in the payment of his own insurance.
15 If he did not wish to do it then that is his business.

16 I believe this covers it. Our estimate
17 would be that it would not be \$3,000,000.00 for this
18 over one hundred thousand, but the assistance might be
19 in the neighbourhood of one-half of that, \$1,500,000.00
20 per annum which would be subsidized by the provincial
21 government to aid this particular group in securing
22 pre-payment insurance if they so desired.

23 I believe this comes as closely as we
24 can at the moment to our concept of the manner by which
25 this might be paid and the amount they might be paid
26 towards this.

27 COMMISSIONER FIRESTONE: You and your
28 associates are to be complimented for having given a
29 serious consideration to a plan which will not only cover
30 the group which it already covers, but, more important,



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\$40,000,000.00 per year in the event these people are
checked or looked at or if they applied it is entirely
they would all need total assistance. The provincial
government might give them total assistance in the pro-
payment but it is more likely they would subsidize and
we would feel they should subsidize by contributing to
the individual receiving assistance in that form and
receiving assistance in the payment of his own insurance.
If he did not want to do it then that is his business.
I would be that it would not be \$3,000,000.00 for this
over one hundred thousand, but the assistance might be
in the neighborhood of one-half of that, \$1,500,000.00
per annum which would be subsidized by the provincial
government to aid this particular group in securing
pre-payment insurance if they so desired.
I believe this comes as closely as we
can at the moment to an estimate of the manner by which
this might be paid and the amount they might be paid
towards this.
COMMISSIONER WILKINSON: You and your
associates are to be congratulated for having given a
serious consideration to a plan which will not only cover



1 the groups not already covered, the medical indigents.
2 This group, you have suggested, the state should make a
3 contribution to.

4 May I rephrase what you have explained
5 to us perhaps in a sentence or two if I have the proper
6 understanding of what you have been telling us. The
7 principle which you support is that those that can afford
8 to pay for such services by premium or other means should
9 pay, and those who cannot afford other than the total
10 cost or only part of a cost should be paid by the state?

11 DR. THOMSON: That is right.

12 COMMISSIONER FIRESTONE: When we
13 speak of the state we are referring to the federal and
14 provincial governments?

15 DR. THOMSON: In our concern at the
16 moment we are dealing with the citizens of the province
17 of Alberta and we have concerned ourselves with the
18 provincial government.

19 COMMISSIONER FIRESTONE: According
20 to your definition when you speak of the state you refer
21 to the provincial government?

22 DR. THOMSON: I should qualify it
23 slightly; the municipal governments and the provincial
24 government within our borders.

25 COMMISSIONER FIRESTONE: In other
26 words, the provincial government and the municipal
27 governments which are within the jurisdiction of the
28 provincial government?

29 DR. THOMSON: That is right.

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12 COMMISSIONER BIRNSTONE: When we
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25 COMMISSIONER BIRNSTONE: In other
26 words, the provincial government and the municipal
27 governments which are within the jurisdiction of the
28 provincial government?
29 DR. THOMSON: That is right.
30 COMMISSIONER BIRNSTONE: It has been



2
1 suggested to us if there is a significant extension of
2 a medical care plan that some of the provinces may find
3 it difficult to pay for the whole programme and they
4 wish to receive some support from the federal government.
5 Now, if such a situation were to develop and the federal
6 government were to develop a plan whereby it would make
7 financial contributions to the provinces to pay for some
8 of the cost of the programme, would your association
9 support such a federal plan?

10 DR. THOMSON: We feel this could be
11 supported in principle but we would like to make the
12 comment at this time that we would trust that such moneys
13 made available would be applied for those who need the
14 assistance and not be applied to all the people.

15 COMMISSIONER FIRESTONE: That is a
16 very sound observation and perhaps it can be helpful to
17 you in spelling out some of the basic terms of such a
18 federal proposal to see what your views are so you can
19 comment on some specific things rather than on generali-
20 ties. We tried this out on the provincial government
21 of Alberta yesterday, and if I may have the views of your
22 association it would help us a great deal, with the
23 question I have raised yesterday as this setting out of
24 a possible scheme and I am saying this is purely a
25 hypothetical question; we are in the process of
26 negotiating what is feasible and reasonable and accept-
27 able. Let us assume that the federal government were
28 prepared to contribute fifty per cent of the cost of a
29 comprehensive medical care plan. Let us further assume
30 that the federal government would say that such plans



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negotiating what is feasible and reasonable and accept-
able. Let us assume that the federal government were
prepared to contribute fifty per cent of the cost of a
comprehensive medical care plan. Let us further assume
that the federal government would say that such plans



1 should be administered in each province by the province,
2 leaving it to a provincial government to work out
3 incorporation with the medical profession the best
4 system of administering such a programme. For instance,
5 in Alberta the provincial government might decide to use
6 M.S.I. as its designated carrier to administer such a
7 programme. Would you be in favour if the provincial
8 government were to approach M.S.I. to administer such a
9 programme for it, would you support such an approach and
10 would you say it would be a useful thing to have M.S.I.
11 act as the designated carrier?

12 DR. THOMSON: I think there are two
13 questions there; the first you have postulated the
14 federal government making available fifty per cent of the
15 cost of a comprehensive plan and by comprehensive you
16 are saying the service was comprehensive in the form of
17 providing it for every individual in the province?

18 COMMISSIONER FIRESTONE: I have used
19 the term comprehensive in the same sense you have been
20 using it and that is referring to the service that they
21 could bring to the coverage of population. This is one
22 of the subsequent items and I will elaborate as we come
23 along, but right now comprehensive means comprehensive
24 in service according to your definition.

25 DR. THOMSON: Insofar as the arrange-
26 ment between the federal and provincial government might
27 be satisfactory to them. This is probably not our
28 business although in making representations to this
29 Commission we have thoughts with regard to how it could
30 be done in the event that moneys were made available.



should be administered in each province by the province, leaving it to a provincial government to work out incorporation with the medical profession the best system of administering such a programme. For instance, in Alberta the provincial government might decide to use M.S.I. as its designated carrier to administer such a programme. Would you be in favour of the provincial government were to approach M.S.I. to administer such a programme for it, would you support such an approach and would you say it would be a useful thing to have M.S.I.

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between the federal and provincial government might

be satisfactory to them. This is probably not our

business although in making representation to this

Commission we have thought it necessary to how it could

be done in the event that money were made available.



1 We would have no objection to the provincial government
2 using some of those moneys to re-insure or insure
3 through our plan M.S.I.A. or any other plan which would
4 give comprehensive care. This would not necessarily
5 be M.S.I.A., it may be any commercial carrier which met
6 the qualifications or met the specifications.

7 ~~For the purpose of~~ COMMISSIONER FIRESTONE: I appreciate
8 it is a very broad and flexible answer, but if I might
9 ask you a specific question; you realize that if
10 governments have to subsidize plans and they wish to
11 appoint a carrier as a designated carrier, its only
12 ~~inclination~~ inclination would be to operate that carrier which is
13 non-profit and M.S.I.A. is a non-profit institution.
14 Therefore, my specific question would be this, if the
15 provincial government were to go to M.S.I.A. and say
16 "We can obtain these funds for such and such a plan,
17 and we like to have it administered by people who have
18 the confidence of the people of Alberta, who have
19 experience in the field, and we think M.S.I.A. is the
20 best agency to do so", would the medical profession of
21 Alberta support such a proposal?

22 DR. THOMSON: Yes, sir.

23 COMMISSIONER FIRESTONE: Presumably
24 if the federal government were to offer such a contri-
25 bution to provincial governments and you are right in
26 saying the specific arrangement with regard to a matter
27 of federal provincial negotiation, and it would be
28 the provinces negotiating with the different bodies in
29 the province, but assuming the federal government went
30 ahead with such a plan which presumably would require



We would have no objection to the provincial government using some of those moneys to re-insure or insure through our plan M.S.I.A. or any other plan which would give comprehensive care. This would not necessarily be M.S.I.A., it may be any commercial carrier which met the qualifications or met the specifications.

COMMISSIONER FIRESTONE: I appreciate it is a very broad and flexible answer, but if I might ask you a specific question: you realize that if governments have to subsidize plans and they wish to appoint a carrier as a designated carrier, its only institution would be to operate that carrier which is non-profit and M.S.I.A. is a non-profit institution. Therefore, my specific question would be this, in the provincial government were to go to M.S.I.A. and say, 'we can obtain these funds for such and such a plan, and we like to have it administered by people who have the confidence of the people of Alberta, who have experience in the field and we think M.S.I.A. is the best agency to do so', would the medical profession of Alberta support such a proposal?

MR. THOMSON: Yes, sir.

if the federal government were to offer such a contribution to provincial governments and you are right in making the specific arrangement with regard to a matter of federal provincial negotiation, and it would be the provinces negotiating with the different bodies in the province, but assuming the federal government went ahead with such a plan which presumably would require



1 a basic standard of medical services across the country?
2 Supposing they were to say that they wanted it covered
3 in such and such a way, certain basic services, I take
4 it since you are in favour of a comprehensive plan, the
5 comprehensive plan covering all the services, you would
6 have no objection to the federal government spelling out
7 basic and minimum standards across the country?

8 DR. THOMSON: I think the answer to
9 that is no. We would hope that rather than having a
10 minimum that it would be comprehensive, because our
11 concern is, sir, with the individuals who cannot afford
12 to pay for their own coverage, or to have the choice in
13 the type of insurance they would like, that they be
14 given a comprehensive type of service plan, that they
15 will lack for nothing.

16 COMMISSIONER FIRESTONE: What you
17 are saying, Dr. Thomson, you would hope basic services
18 provided in some such plan would be as high as reson-
19 ably could be expected in good medical practice?

20 DR. THOMSON: That is correct, sir.

21 COMMISSIONER FIRESTONE: Then I
22 come to the next point: If the federal government would
23 leave it to the province to work out its own financing
24 arrangements, how it wished to finance this, whether
25 by premium or taxation, you would go along with such an
26 arrangement, sir?

27 DR. THOMSON: Certainly, sir, if
28 the federal and provincial governments came to an agree-
29 ment I think that it would be their business to work out
30 a method by which they would raise moneys. We would.



in such and such a way, certain basic services, I take
it since you are in favour of a comprehensive plan, the
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that is no. We would hope that rather than having a
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are saying, Mr. Thomson, you would hope basic services
provided in a medical plan would be as high as reason-
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MR. THOMSON: That is correct, sir.
COMMISSIONER WILKINSON: Then I

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a method by which they would raise money. It would



1 still be prepared, sir, to suggest that we hope this
2 wouldn't apply to all the people in the province but to
3 those people who need the care.

4 COMMISSIONER FIRESTONE: That is
5 going to be the next point. If I just may finish this
6 point we are discussing now. The suggestion is that
7 leaving it to the province to make its own discussion
8 of how it wishes to arrange for the financing, for its
9 share, you would accept this?

10 DR. THOMSON: It is a provincial
11 responsibility, yes, sir.

12 COMMISSIONER FIRESTONE: Coming to
13 the other point which I think has been on your mind, Dr.
14 Thomson, as to whether everybody would be covered and
15 that presumably by compulsion or only those who are
16 willing to be covered on a voluntary basis. I think
17 you have made very clear to us that your association
18 supports the voluntary plan for the province of Alberta.

19 DR. THOMSON: That is correct, yes.

20 COMMISSIONER FIRESTONE: Now, sir,
21 some provinces may wish to have a compulsory plan. Some
22 provinces may wish to have a voluntary plan, different
23 people in different parts of Canada have different views
24 as to how the scheme should operate. We are a Royal
25 Commission advising the federal government. Therefore,
26 we have to have a plan which meets the needs of different
27 provinces. If the federal government were to come up
28 with a plan saying they would make that fifty per cent
29 financial contribution leaving it to each province to
30 decide whether they wished to have a voluntary plan or



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point we are discussing now. The suggestion is that
leaving it to the province to make its own decision
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share, you would accept that?

MR. THOMSON: Is it a provincial?

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the other point which I think has been on your mind, Mr.
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Some provinces may wish to have a compulsory plan. Some
provinces may wish to have a voluntary plan. Different
people in different parts of Canada have different views
as to how the scheme should operate. We are a Royal
Commission advising the federal government. Therefore,
we have to have a plan which meets the needs of all
provinces. If the federal government were to come up
with a plan saying they would make that fifty per cent
financial contribution leaving it to each province to
decide whether they wished to have a voluntary plan or



1 a compulsory plan, would you be in favour of such a
2 proposal?

3 DR. THOMSON: This is something
4 which again I think would be outside of our areas of
5 concern. The decision as whether it would be voluntary
6 or compulsory would be a decision to be made by the
7 provincial government. Then I think that this decision
8 of how the money, one would have to look at the situation
9 after it developed and as it was developing to see
10 whether there are any features in that particular plan
11 which might work to the detriment of the people of the
12 province who are going to receive the service.

13 This might include the professions who
14 are going to provide these services. I don't think I
15 can give you a direct yes or no answer to that question
16 at the moment.

17 COMMISSIONER FIRESTONE: Sir, you
18 appear to be quite happy to leave to the federal,
19 provincial governments, in other words, if the provinces
20 across Canada are prepared, some are insisting on
21 compulsory, some insist they want to introduce a volun-
22 tary arrangement, you would have no objection to leave
23 these arrangements to the federal, provincial discretion?

24 DR. THOMSON: Professor Firestone,
25 when you ask whether we would have any agreement or dis-
26 agreement, I would still have to go back to the basic
27 premise as to what type of assistance, was this being
28 given to all the people or only to the certain segment
29 of the province. If it is given to all the people who
30 need assistance, then I am sure we would be concerned,



a compulsory plan, would you be in favour of such a proposal?

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are going to provide these services. I don't think I can give you a direct yes or no answer to that question at the moment.

COMMISSIONER WESTON: Sir, you

appear to be quite happy to leave to the federal provincial governments, in other words, if the provinces across Canada are prepared, some are holding on compulsory, some insist they want to introduce a voluntary arrangement, you would have no objection to leaving these arrangements to the federal, provincial discussions.

DR. THOMSON: Professor Weston.

When you ask whether we would have any agreement or disagreement, I would still have to go back to the basic premise as to what type of assistance, and this being given to all the people or only to the certain segments of the province. If it is given to all the people who need assistance, then I am sure we would be concerned,



1 we would be in accord with the provincial and federal
2 government participating.

3 If it was made a subsidy to all the
4 people of the province, I don't think we could agree to
5 that at the moment. We couldn't lend it our whole
6 hearted support and say yes we would agree to it.

7 COMMISSIONER FIRESTONE: That is very
8 reasonable, Dr. Thomson.

9 What I am posing is the question that
10 under such a plan as we are now discussing, the federal
11 government would leave it to the good judgment of the
12 provinces and the people, the provinces' judgment,
13 whether the plan would cover everybody or seventy-five
14 per cent or eighty-five per cent. All I am saying is
15 that the federal government under this sort of
16 arrangement are not saying to the provinces they must
17 cover one hundred per cent, they should cover the
18 majority of population. Some suggested sixty-five or
19 seventy-five per cent. Under no circumstances does
20 the plan envisage compulsion for everybody. It leaves
21 it to the good judgment of the province and the people
22 of the province to decide what plan is suitable for
23 them. Would you go along?

24 DR. THOMSON: Professor Firestone,
25 the medical profession in Albert couldn't, at the
26 moment, go along with that, because while we are talking
27 about a hypothetical situation, it is still a rather
28 violent contrast to the procedure which we feel we would
29 like to see applied, that is, to insist that you cannot
30 afford it. Therefore, to say we would go along with it



1 whether it was compulsory or not, leaving it to the
2 judgment of the provinces, I think we would have to say
3 at the present time, because presumably you ~~were~~ talking
4 about a certain percentage of the people being covered,
5 which means that in this essence it is compulsory.

6 COMMISSIONER FIRESTONE: Perhaps
7 we should discuss the feature of the number of people
8 that would be covered first. Let us say the federal
9 government would say this plan would go into effect in
10 the province that they were only going to get seventy-
11 five per cent of the population covered, or sixty-five
12 per cent, I am using a majority percentage because you
13 can't expect the federal government to spend the tax
14 money for a minority. It would never meet parliamentary
15 favour until a majority is covered.

16 DR. THOMSON: This would probably
17 be one area in which I would have to offer some objection.
18 In other words, we would be able to go along with your
19 proposal itself because of the fact that you are not
20 applying the assistance where it is necessary. It is
21 applying it to a certain percentage and not necessarily
22 the needy will get it.

23 If, Mr. Chairman, I might digress for
24 a moment, I am sorry, I don't know the reasons behind
25 federal thinking, why couldn't it apply to a specific
26 area of need as opposed to covering the total population.
27 The payment for wheat surpluses or for loss of wheat
28 grown is not. I am not aware of the mechanism by which
29 it works out, sir, but I am sure some assistance must
30 be given in different places to those who need, opposed



1 to all. I simply raise this question. This is presuming
2 that the federal government wouldn't give assistance
3 unless it covered all.

4 THE CHAIRMAN: Doctor, rather than
5 you be under any misapprehension, there is no suggestion
6 that the question involved any implication of federal
7 thinking. You would be completely wrong in thinking that.
8 I mean to say this Commission has no mandate in any
9 form. It is purely a survey and advisory Commission.
10 It doesn't represent and no statements made represent in
11 any way government policy at any government level.

12 DR. THOMSON: I appreciate that,
13 Mr. Chairman. If I might explain, I was bringing out the
14 thought that had occurred to us in view of the others.

15 THE CHAIRMAN: I follow you completely.
16 As a matter of fact, I think you have answered the
17 question half a dozen times.

18 COMMISSIONER McCUTCHEON: I was
19 simply going to say that there are many, many cases where
20 the federal government pays out tax moneys to certain
21 minority groups, and particularly in the field of public
22 assistance and old age assistance and so on, and so on.
23 The fact that they pay out tax moneys to the majority
24 of people is quite wrong. That I think is the point you
25 are making.

26 DR. THOMSON: That is what I had in
27 mind. I had no intention to raise the thought in that
28 direction at all.

29 THE CHAIRMAN: It was the way you
30 put it. I just wanted to make it clear.



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direction at all.

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put it. I just wanted to make it clear.



1 DR. THOMSON: Thank you very much,
2 sir.

3 COMMISSIONER FIRESTONE: To come to
4 this question of voluntary and compulsory, I quite
5 appreciate the position of your association, but you are
6 in favour of a voluntary programme for the province of
7 Alberta.

8 In fact, the Minister of Health yes-
9 terday endorsed the same sort of approach. The fact
10 remains, sir, there are some provinces that wish to have
11 a compulsory programme. Now, we as a Royal Commission
12 are advising the federal government that may wish to
13 come forward with a plan that can be used in the
14 province that wishes to have a compulsory plan and the
15 province that wishes to have a voluntary plan.

16 Would you feel that the medical
17 profession in the province of Alberta would want to take
18 the view that if people in another provinces wanted a
19 different type of system, they couldn't have such
20 a system because it would hurt your position?

21 DR. THOMSON: Professor Firestone,
22 I think the attitude of the profession in Alberta
23 wouldn't be with regards to whether it would hurt their
24 position. They would feel, I believe, that the profession
25 in another province would have the right to determine,
26 just as the government of the province has the right
27 to determine what its legislation might be. One would
28 if we were asked what do you think of that, we have
29 tried to present for your consideration a proposal which
30 we feel is reasonable, proper, workable in this area,



Thank you very much.

COMMISSIONER FIRESTONE: To come to

this question of voluntary and compulsory, I quite appreciate the position of your association, but you are in favour of a voluntary programme for the province of

In fact, the Minister of Health yes-

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profession in the province of Alberta would want to take the view that if people in another province wanted a different type of system, they couldn't have such a system because it would hurt your position?

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wouldn't be with regard to whether it would hurt their position. They would feel, I believe, that the profession in another province would have the right to determine, just as the government of the province has the right to determine what legislation might be. One would if we were asked what do you think of that, we have tried to present for your consideration a proposal which we feel is reasonable, proper, workable in this area.



1 and might again be a pattern which could work across
2 the country. Therefore, for us to disagree with some-
3 body else's method of securing medical services would
4 be probably on a personal basis. We would have to say
5 we didn't like it and for the various reasons, or we
6 did like and for the various reasons. I don't think we
7 would have any thought of interfering with a proposal
8 brought forward by some other area, segment of the
9 profession, and governments other than our own.

10 COMMISSIONER FIRESTONE: And if you
11 visualize a scheme that would be flexible enough to take
12 care of different things in different conditions,
13 depending upon the wishes of the people in different
14 regions

15 DR. THOMSON: I thought we had,
16 sir, in what we had proposed.

17 COMMISSIONER FIRESTONE: I think that
18 answers my question.

19 My last question is: That assuming
20 such a federal plan were developed and the provincial
21 government was accepting this plan on the basis of
22 many negotiations and discussions and worked out the
23 details, would the medical profession support the
24 provincial plan, administered and sponsored by the
25 provincial government, on a comprehensive and voluntary
26 basis if it covers the majority of the population, sixty-
27 five or whatever percentage it might be?

28 DR. THOMSON: I wonder, sir, if you
29 are postulating a position that might be destructive as
30 we already have plans and insurance groups which cover



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depending upon the wishes of the people in different

DR. THOMPSON: I thought we had,

air, in what we had proposed.

DR. THOMPSON: I think what

answers my question.

The last question is: Just assuming

such a federal plan were developed and the provincial

government was according this plan on the basis of

many negotiations and discussions and worked out the

details, would the medical profession support the

provincial plan, administration and sponsored by the

provincial government, or a comprehensive and voluntary

basis if it covers the majority of the population, sixty-

live or whatever percentage, it might be?

DR. THOMPSON: I wonder, sir, if you

are postulating a position that might be destructive as

we already have plans and insurance groups which cover



1 a large percentage of the population.

2 Incidentally, our pre-paid plans are
3 growing. They are still in the process of development
4 and there may be certain difficulties, but they are
5 generally working to try and smooth and iron out these
6 difficulties in their areas, which might be unmet this
7 way.

8 Now, you are asking me to think in terms
9 of the government putting in what is already covered to
10 a large extent. In other words, we have some sixty odd
11 per cent with some form of coverage now, and you are
12 postulating the government put it in. You are asking me
13 to try and wash out what is here and think in terms of
14 somebody putting it in. I still say that this may be
15 rather -- my colleagues and I are in a rather difficult
16 position to answer it. If it is purely theoretical
17 and philosophical, I would say why destroy what we have
18 in order to bring in something that may not be any better.

19 DR. GRISDALE: One question that
20 might help. Do you mean this group would be receiving
21 government assistance in this plan?

22 COMMISSIONER FIRESTONE: No, sir.
23 Dr. Thomson indicated a little earlier, he indicated
24 the procedure of payment would be for us to pay for the
25 plan, and those that couldn't, receive state assistance
26 -- we define state as province. The province would pay
27 for it, and if it was too heavy a burden, the federal
28 government would help. That is what I understood. Please
29 feel free, if you find the question a little complex
30 or philosophical, by all means, I will clarify it.



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30 government would help. That is what I understood. Please
31 feel free, if you find the question a little complex
32 or philosophical, by all means, I will clarify it.



1 DR. THOMSON: It is complex to me at
2 the moment.

3 COMMISSIONER FIRESTONE: May I suggest
4 if you wish to consider the question, discuss it with
5 your colleagues and let me have your answer in writing.

6 DR. THOMSON: I am not sure what
7 it is you want answered. I would have to ask for some
8 further direction on that. You have said would you be
9 prepared to support a plan which provided sixty-five or
10 more or some other percentage of the population would
11 be covered. I suggest, sir, insofar as we already have
12 plans covering a good percentage of our population, I
13 find it difficult to envisage a situation I have
14 destroyed this and simply brought in the state to take
15 its place.

16 THE CHAIRMAN: You might answer
17 after further consideration that you find it impossible
18 to answer the question.

19 COMMISSIONER FIRESTONE: I think you
20 are getting a little help. You have done very well in
21 your answers. I am just trying to be helpful to you
22 again, sir.

23 When you are speaking of the government,
24 you will recall I have suggested earlier that the
25 government main role would be, (a) to set standards,
26 comprehensive standards and, (b) to make financial
27 contributions. We have also suggested there is a
28 possibility the provincial government may use M.S.I. as
29 a designated carrier. I listed half a dozen points, I
30 said under those conditions would you support such a plan.



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1 Therefore, my question is not relating to the situation
2 taken out of its context. It is to the six different
3 aspects we have discussed over the last thirty minutes.
4 That is why I am suggesting if you wish, because of the
5 complexity, if you can take it under advisement,
6 consider all the ramifications, and let us have your
7 answer after further consultation, or any time at your
8 convenience.

9 DR. THOMSON: I think, Professor
10 Firestone, I think we should probably try to make our-
11 selves clear at this point. We feel we have given this--

12 THE CHAIRMAN: I understand you
13 don't want the implication you are supporting the validity
14 of any part of the question?

15 DR. THOMSON: That is correct, sir.

16 THE CHAIRMAN: I see your situation.
17 It is implicit in the question you are going to accept
18 some conditions which are repugnant to you?

19 DR. THOMSON: One would feel this is
20 so, sir, and that is why -- I think I have answered them.
21 I have tried to answer those portions which we didn't
22 accept. I don't feel we will have to study. I don't
23 feel we will have to spend more time in order to give you
24 an answer to that question.

25 COMMISSIONER FIRESTONE: Fine, thank
26 you very much, sir.

27 THE CHAIRMAN: Dr. Van Wart.

28 COMMISSIONER VAN WART: I want to
29 take you to something that was on earlier in the day,
30 that is the question of over-utilization.



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taken out of its context. It is to the six different
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an answer to that question.

you very much, sir.
THE CHAIRMAN: Dr. Van Wart.
COMMISSIONER VAN WART: I want to
take you to something that was on earlier in the day,
that is the question of over-utilization.



1 It was drawn out the position of the
2 doctors in the utilization of hospital beds. What I
3 wanted to find out, there are other factors, do they
4 exist in your province, for example, diagnostic surveys
5 such as x-rays and pathology, delay in getting diagnostic
6 surveys through, delay in your nursing services, in
7 getting your rooms ready, delays due to the forty-hour
8 week and not working on weekends, are these not factors
9 that go into the utilization of beds?

10 DR. THOMSON: It is, Dr. Van Wart.
11 Those are factors that come into the utilization of beds.
12 One might feel, however, that the diagnostic problems,
13 the facilities as far as nursing are concerned, are
14 far less important than the maintenance of chronic
15 individuals in hospitals.

16 COMMISSIONER VAN WART: That is all
17 I wished to ask.

18 THE CHAIRMAN: Thank you very much,
19 Dr. Thomson and gentlemen for your patience and your help
20 and for the time and thought that went into the prepara-
21 tion of your brief.

22 DR. THOMSON: Thank you very much,
23 Mr. Chairman. On behalf of my colleagues, on behalf of
24 the College, the Association and Faculty of Medicine,
25 we would like to extend to you our best wishes for your
26 future efforts as well as thanks for past time and
27 particularly we thank you for this opportunity of being
28 here.

29 THE CHAIRMAN: The next submission
30 will be from the Faculty of Dentistry of the University



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THE CHAIRMAN: Thank you very much.
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--- EXHIBIT NO. 116:

Submission of the
University of Alberta,
Faculty of Dentistry.

SUBMISSION

of the

UNIVERSITY OF ALBERTA

FACULTY OF DENTISTRY

APPEARANCES:

DR. H. R. MacLEAN

DR. C. W. McPHAIL

DR. K. A. McMURCHY

DR. C. R. CASTALDI

DR. H. R. MacLEAN: Mr. Chairman and
members of the Commission, I am H. R. MacLean, Dean of
the Faculty of Medicine, University of Alberta.

I should like to introduce to you three
consultants whom I have with me. Dr. McPhail, who is
in charge of the Department of Public Health and of our
auxiliary programme. Dr. McMurchy, who is in charge of
our scholarship committee and students support, and Dr.
Castaldi, who is on our research committee and also our
hospital committee.

If I might read the summary and
recommendations, Mr. Chairman.



1 of Alberta.

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EXHIBIT NO. 100: ---

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UNIVERSITY OF ALBERTA

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DR. H. H. MASON

MR. C. W. McPHAIL

DR. K. A. McPHERSON

MR. C. R. CASTLE

DR. H. H. MASON: Mr. Chairman and

members of the Commission, I am H. H. Mason, Dean of

the Faculty of Medicine, University of Alberta.

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If I might read the summary and

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SUMMARY

Dental and oral disease affects almost 100 percent of the population. It is not practical, nor economically feasible, to control the problem by treatment methods alone. Every proven means of prevention and control must be promoted and instituted as soon as possible. The Faculty is disappointed that the benefits of fluoridation have not been made available to a greater number of communities.

An attempt has been made to outline the existing problems in dental education as they relate to the present and future needs of the residents of Alberta and of Canada as a nation.

These needs are discussed from the points of view of dental manpower, recruitment, academic staff, research, health education, hospital services and physical facilities. These factors have been carefully considered not only from the point of view of need and demand, but also with regard to achieving the optimum in dental health in its most economical manner without lowering standards or creating overburdening costs.

RECOMMENDATIONS

The following recommendations are submitted to the Royal Commission on Health Services by the Faculty of Dentistry of the University of Alberta.



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100 percent of the population. It is not practical, nor
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the present and future needs of the residents of Alberta
and of Canada as a nation.
These needs are discussed from the
points of view of dental manpower, recruitment, academic
staff, research, health education, hospital services and
considered not only from the point of view of need and
demand, but also with regard to achieving the optimum
in dental health in its most economical manner without
lowering standards or creating overwhelming costs.

The following recommendations are
submitted to the Royal Commission on Health Services by
the Faculty of Dentistry of the University of Alberta.



1 1 (paras 9, 10, 11, 12, Immediate consideration should
2 13, 14, 15, 16, 70, given to the dental manpower
3 71, 72, 73) needs of this country in re-
4 lation to existing training
5 facilities and their future
6 expansion.

7 2 (paras 17, 18, 19) The following points are
8 recommended relating to dental
9 auxiliary personnel:
10 (a) services be integrated and
11 provided under the supervision
12 or direction of a licensed
13 dentist who shall assume full
14 responsibility;
15 (b) that auxiliary personnel
16 shall include the dental tech-
17 nician, the dental assistant,
18 the dental hygienist (and the
19 Dental Auxiliary (Alberta) when
20 these auxiliaries are graduated);
21 (c) that the licensing of all
22 dental auxiliaries is a pro-
23 vincial responsibility but that
24 a plan of certification
25 similar to the National Dental
26 Examining Board be sought; and
27 (d) that it be recommended to
28 faculties of dentistry that
29 attention be given to training
30 dental students to use efficient



(para 9, 10, 11, 12,

13, 14, 15, 16, 17,

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3 (paras 20, 21,22)

the services of all dental
auxiliaries.

The training and status of
dental hygienists should give
consideration to the following
points:

(a) that the term "Dental
Auxiliary (Alberta)" be changed
to "dental hygienist" for purposes
of national recognition, evalu-
ation and classification;

(b) that the Dental Auxiliary
(Alberta) be permitted to work
in private dental offices, as
well as in public health services
at the earliest practical date;
and

(c) that Dental Auxiliary
(Alberta) students be permitted
the choice of registereing and
paying their own tuition, with
freedom of choice of employment
on graduation, as well as the
choice of receiving the govern-
ment bursary with a return in
service commitment.

4 (paras. 23, 24, 25)

The Faculty recommends that
consideration be given to a
comprehensive course of training
for dental assistants in



the services of all dental
auxiliaries.

3 (paras 20, 21, 22)

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choice of receiving the govern-
ment bounty with a return in
service commitment.

4 (paras 23, 24, 25)

The Faculty recommends that
consideration be given to a

for dental assistants in



1 vocational schools.

2 5 (Para. 26) The Faculty recommends that

3 consideration be given to the

4 establishment of a training

5 school for dental laboratory

6 technicians for all of Western

7 Canada supported both Federally

8 and Provincially.

9 6 (Paras. 28, 29, 30, The Faculty recommends the

10 31, 32, 33) following as a guide to the

11 problem of recruitment;

12 (a) that the best academic pre-

13 diction for applicants to den-

14 tistry is their high school or

15 previous university scholastic

16 record;

17 (b) that a basic percentage is

18 required by the Admissions

19 Committee because experience has

20 shown that applicants with

21 records below 60% will not be

22 successful in the dental program;

23 (c) that a recruitment program

24 should also strive to interest

25 more young women in dentistry as

26 a career;

27 (d) that dentistry, as a pro-

28 fession with opportunities for

29 graduates in allied fields such

30 as research and public health,



vocational schools.

(Para. 26)

The Faculty recommends that consideration be given to the establishment of a training school for dental laboratory technicians for all of Western Canada supported both Federally and Provincially.

(Para. 28, 29, 30)

(31, 32, 33)

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(a) that the best academic preparation for applicants to dentistry is their high school or previous university education; record;

(b) that a basic percentage is required by the Admissions

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(c) that a recruitment program should also strive to interest

more young women in dentistry as a career;

(d) that dentistry, as a profession, should be encouraged in allied fields such as research and public health.



1 should receive more publicity
2 directed to the lay public;
3 (e) that recruitment of well-
4 qualified applicants to the den-
5 tal hygiene program should be
6 instituted as well; and
7 (f) that support should be given
8 to the national recruitment
9 program already organized by the
10 Canadian Dental Association and
11 to provincial recruitment
12 committees in order to attract
13 better students in larger numbers
14 to dentistry.
15 7 (Para. 38) The following points are
16 recommended in the student finan-
17 cial aid program:
18 (a) that the residence requirement
19 be deleted from Federal-Provin-
20 cial student aid schemes;
21 (b) that scholarships in the form
22 of tuition be provided for 10
23 percent of dental students;
24 (c) that loans for tuition, books
25 and equipment be available with
26 no means test; and
27 (d) that a partial subsidization
28 plan be made available for 10
29 percent of dental students.
30 8 (paras. 40, 41, 42) Academic staff needs should be



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no means test; and
that a loan fund be made available for 10
percent of dental students.
Academic staff needs should be

8 (paras. 40, 41, 42)



1 43, 44, 45, 46, aided with some form of financial
2 47, 48) assistance planned and made
3 available to support graduate
4 training that is directed toward
5 the need for more full-time
6 teachers in the dental schools
7 of Canada.

8 9 The following points should be
9 considered with respect to
10 research in dentistry:

11 (paras. 49, 50, 51, (a) A severe shortage of qualified
12 52, 53, 54, 55, 56, teachers in dental science and
13 57, 58) clinical dentistry exists in
14 Canada. Postdoctoral fellowships
15 in the range of \$4,000-\$6,500
16 should be made available to en-
17 courage dental graduates to take
18 up careers in dental research and
19 teaching.

20 (Paras. 59, 60, 61) (b) Larger amounts of money
21 should be made available to
22 support dental research. The
23 source of this money should be
24 increased not only from public
25 sources but from industry as well.

26 (Para. 62) (c) Consideration should be
27 given to the establishment of a
28 national institute of dental
29 research.

30 10 (paras. 63, 64, 65) The university should take a role



43, 44, 45, 46, 47, 48)

...with some form of financial assistance planned and made available to support graduate training that is directed towards the need for more full-time teachers in the dental schools of Canada.

The following points should be considered with respect to research in dentistry:

(paras. 49, 50, 51)

(a) A severe shortage of qualified teachers in dental schools and

52, 53)

Canada. Postdoctoral fellowships

should be made available to encourage dental graduates to take up careers in dental research and teaching.

(paras. 54, 55, 56, 57)

(b) Larger amounts of money should be made available to support dental research. The amount of this money should be increased not only from public

(para. 58)

(c) Consideration should be given to the establishment of a national institute of dental



1 in educating the public in
2 health matters, not only be
3 assisting in the coordination of
4 activities of all bodies present-
5 ly engaged in health education,
6 but also by increased research
7 in health education.

8 11 (Paras. 66, 67, 68, The following recommendations are
9 69) made with regard to hospital
10 service.

11 (a) Dentists should have a
12 clearly defined legal status in
13 hospitals and this should be
14 uniform throughout Canada.

15 (b) Hospitals should be permitted
16 to use hospital funds for the
17 purchase of equipment necessary
18 to carry out dental treatment
19 services under general anesthesia.

20 (c) All chronic disease hospitals
21 should have facilities and equip-
22 ment to provide routine dental
23 treatment services.

24 This completes the recommendations,
25 Mr. Chairman.

26 THE CHAIRMAN: Thank you very much,
27 Dr. MacLean.

28 COMMISSIONER STRACHAN: The Dean has
29 made everything so clear, so far as I am concerned
30 questioning will be a minimum.



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 health matters, not only be
 assisting in the coordination of
 activities of all bodies present
 but also by increased research
 in health education.

The following recommendations are
 made with regard to hospital

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(a) Dentists should have a
 clearly defined legal status in
 hospitals and this should be

(b) Hospitals should be permitted
 to use hospital funds for the
 purchase of equipment necessary
 to carry out dental treatment

(c) All chronic disease hospital
 should have facilities and equip-
 ment to provide routine dental

This completes the recommendations,

THE CHAIRMAN: Thank you very much,

COMMISSIONER OF STATION: The Dean has

made everything so clear, so far as I am concerned



1
2 Mr. Chairman, I am struck by the fact
3 that on page 21 the Dean has, for the first or second
4 time, dared to make another point regarding the control
5 of dental caries, and that is at paragraph 61 referring
6 to the relationship of sugar and sugar containing foods
7 to dental caries.

8 "Because of the proven relationship
9 of sugar and sugar containing foods to dental
10 caries, the sugar and food processing industries
11 in this country have a public responsibility
12 to support dental research by contributing
13 funds to Canadian dental schools."

14 I think that is a point that has not
15 been stressed sufficiently. I have no question to ask
16 Dean MacLean on that.

17 Regarding paragraph 7 of your recommen-
18 dations, Dean MacLean, what ten per cent do you refer to
19 there in (b) and (d)?

20 DR. MacLEAN: Dr. Strachan, I would
21 like to refer this question to Dr. McMurchy, who is in
22 charge of our scholarship funds. I think he is more
23 familiar with that.

24 DR. McMURCHY: This is paragraph 7?

25 COMMISSIONER STRACHAN: Yes, part (b)
26 and part (d).

27 DR. McMURCHY: That was just an esti-
28 mation, the (d) part there, subsidization, as to the
29 number of students that could possibly be utilized in
30 health services on a full-time basis after graduation.



1 In part (b), a scholarship in the form
2 of tuition be provided for ten per cent of dental students.
3 This is an arbitrary figure, the top ten per cent.

4 COMMISSIONER STRACHAN: The top ten
5 per cent figure?

6 DR. McMURCHY: Within the faculty,
7 yes.

8 COMMISSIONER STRACHAN: The (d) does
9 not refer to the ten per cent ---

10 DR. McMURCHY: No, this is a different
11 ten per cent.

12 COMMISSIONER STRACHAN: Yes, I would
13 think so.

14 Would you explain (a) a little further
15 for us, please?

16 DR. McMURCHY: At the present time,
17 the federal-provincial assistance is given to the various
18 provinces and in the Faculty of Dentistry we have students
19 from the four western provinces, and this creates a
20 difficulty in that our students, some of them have to
21 apply to British Columbia, some to Alberta, some to
22 Saskatchewan, and some to Manitoba. It is difficult --
23 these systems differ slightly in details, and in some
24 cases the treatment of students within the Faculty of
25 Dentistry, our Faculty of Dentistry, is a little erratic
26 because of this. Our suggestion is that when a student
27 becomes a student in dentistry in Alberta, that he be then
28 eligible for the federal-provincial assistance through
29 the Alberta regulations.

30 COMMISSIONER STRACHAN: I think that



1 is all I have, Mr. Chairman.

2 THE CHAIRMAN: Do you infer from that
3 that if you have a student from Manitoba or Saskatchewan
4 -- that is, a non-Alberta student -- that he would use up
5 part of the moneys available to the Alberta student?

6 DR. McMURCHY: Yes, that would be the
7 case, if this went through.

8 THE CHAIRMAN: As it is now, because
9 he comes from Manitoba or Saskatchewan, may he apply to
10 have moneys that are available to those provinces?

11 DR. McMURCHY: Yes, He may, that is
12 true.

13 COMMISSIONER STRACHAN: There is one
14 question I would like to include there.

15 THE CHAIRMAN: Yes, go ahead.

16 COMMISSIONER STRACHAN: I am not
17 quite sure of the proper term used by the government ---
18 federal-professional funds, something of that nature?

19 DR. McMURCHY: Federal-provincial
20 funds?

21 COMMISSIONER STRACHAN: Yes -- training
22 grants. Would those be available to non-Alberta residents
23 to come to Alberta?

24 DR. McMURCHY: I am not quite clear
25 on what training grants these are.

26 COMMISSIONER STRACHAN: They are the
27 National Health Grants. They are the National Health
28 Training Grants. They were referred to by the government
29 submission yesterday.

30 DR. MacLEAN: Probably Dr. McPhail



as all I have, Mr. Chairman.

THE CHAIRMAN: Do you infer from that

that if you have a student from Manitoba or Saskatchewan

-- that is, a non-Alberta student -- that he would use up

part of the money available to the Alberta students?

MR. McMURCHY: Yes, that would be the

case, if this went through.

THE CHAIRMAN: As it is now, because

he comes from Manitoba or Saskatchewan, may he apply to

have money that are available to those provinces?

MR. McMURCHY: Yes, he may, that is

true.

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THE CHAIRMAN: Yes, go ahead.

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quite sure of the proper term used by the Government --

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on what training grants these are.

COMMISSIONER STRACHAN: They are the

National Health Grants. They are the National Health

Training Grants. They were referred to by the Government



1 could answer that, Mr. Chairman.

2 DR. McPHAIL: The present situation
3 there with regard to the dental auxiliaries we enrolled
4 in the University of Alberta, some are from outside the
5 province, but they are eligible to receive these
6 professional training grants, but with this there is a
7 return in service commitment.

8 COMMISSIONER STRACHAN: For Alberta?

9 DR. McPHAIL: For Alberta, yes.

10 And as far as the dentists, they must be in the services
11 of health units in the province in order to receive this
12 professional training grant.

13 COMMISSIONER STRACHAN: They could only
14 get into Alberta if they were going to serve in Alberta?

15 DR. McMURCHY: Yes, that is the
16 present situation.

17 COMMISSIONER STRACHAN: That is basic,
18 isn't it, as far as it is concerned now?

19 DR. McMURCHY: Yes.

20 COMMISSIONER STRACHAN: Thank you, sir.

21 THE CHAIRMAN: This item (c) in
22 paragraph 7 of the recommendations regarding loans for
23 tuitions, books and equipment being available with no
24 means test. From the face of it, it looks as though
25 somebody who does not need a loan could just go in and
26 get it. Do you mean that?

27 DR. McMURCHY: Well, this stems from
28 the difficulties of assessing the need of a student, and
29 we have quite a complicated mechanism over there now.
30 We thought here to put the onus more on the student as

could answer that, Mr. Chairman.

there with regard to the social scientists we enrolled
in the University of Alaska, some are from outside the
province, but many are eligible to receive these
professional training grants, but with this there is a
return in research commitment.

MR. WATKINS: For Alaska, yes

And as far as the doctor, they must be in the category
of health care in the province in order to receive this
professional training grant.

MR. WATKINS: They could not

get in a situation if they were going to serve in Alaska?
MR. WATKINS: Yes, that is true.

General statement

January 1, as far as it is concerned now?

MR. WATKINS: Yes.

MR. CHAIRMAN: This item (c) is

paragraph 7 of the recommendation regarding loans for
students, loans and equipment being available with no
interest rate, and the issue of it, it looks as though
somebody who does not need a loan could just go in and
get it. Do you mean that?

MR. WATKINS: Well, this seems from

the difficulties of assessing the need of a student, and
we have given a complicated mechanism over those now.
We thought here to put the emphasis on the student as



1 to whether he should borrow money or not, and I think if
2 we made money readily available to the student, and that
3 he would have to pay it back with interest after he
4 graduated, with normal interest rates -- bank interest
5 rates -- that this would be enough of a deterrent to the
6 student to take only what he really needed.

7 Now, I think that it would be a simpler
8 procedure.

9 THE CHAIRMAN: Even though he has
10 means of his own, or his family has, or ---

11 DR. McMURCHY: Well, if he had means,
12 I think if he thought it over he would not borrow the
13 money.

14 THE CHAIRMAN: That is your idea, in
15 any event?

16 DR. McMURCHY: Yes, -- that is my
17 hope.

18 THE CHAIRMAN: Paragraph 11. Dentists
19 should have a clearly defined legal status in hospitals,
20 and this should be uniform throughout Canada. Having
21 regard to the fact that the classes of dentistry, as
22 with medicine, and as with C.D. and E. hospitals, and so
23 forth, within the provincial jurisdiction, have you any
24 suggestion to offer as to how this recommendation might
25 be implemented?

26 DR. CASTALDI: Under the present
27 arrangement of Dominion and provincial grants for hospitals,
28 it is our understanding that equipment is not to be used
29 for dental services.

30 THE CHAIRMAN: I am talking about (a)



to whether he should borrow money or not, and I think if
 we have money readily available to the student, and that
 he would have to pay it back with interest after he
 graduated, with normal interest rates -- bank interest
 rates -- that this would be enough of a deterrent to the
 student.
 Now, I think that it would be a singular

THE CHAIRMAN: Even though he has
 means of his own, or his family has, or ---
 DR. MEMORIEL: Well, it is not unusual
 I think if he thought it over he would not borrow the
 money.

THE CHAIRMAN: That is your idea, is
 any other?
 MR. MEMORIEL: Yes, -- that is my
 hope.

THE CHAIRMAN: Paragraph 11. Dentists
 should have a legally defined legal status in hospitals,
 and this should be uniform throughout Canada, having
 regard to the fact that the classes of dentistry, as
 with medicine, and as with C.D. and E. hospitals, and so
 forth, within the provincial jurisdiction, have you any
 suggestion as to how this recommendation might
 be implemented?

THE CHAIRMAN: I am talking about (a)
 it is our understanding that equipment is not to be used
 for dental services.



CH/DD

1 now.

2 DR. CASTALDI: Well, on page 22,
3 paragraph 66 it states there that there is no clearly de-
4 ~~finedelegal status~~ and I understand the Canadian Dentists
5 Association is concerned about this. From discussions
6 that are now going on with the Canadian Hospitals
7 representatives, it would seem to me that admitting the
8 patients should be primarily a joint responsibility.

9 THE CHAIRMAN: I do not think we
10 need have any discussion on that because that principle
11 has been put forward. What you are saying is they should
12 have a defined legal status in Canada in hospitals
13 uniform throughout Canada?

14 DR. CASTALDI: Yes.

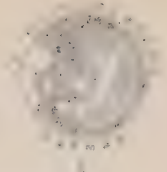
15 THE CHAIRMAN: And how would you
16 propose that to be established having regard to the fact
17 that it is within provincial jurisdictions, the Dominion
18 government can be told to stay out of this field? I
19 mean, is this more than a pious hope, can it be more than
20 that?

21 DR. CASTALDI: I think it is some-
22 thing that should be worked towards.

23 THE CHAIRMAN: Do you mean an amend-
24 ment to the British North America Act?

25 DR. CASTALDI: No, I think these
26 things should be worked out first through the provinces
27 and with the provinces.

28 THE CHAIRMAN: But in terms of this
29 Commission, any recommendation this Commission might be
30 able to make?



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that are now going on with the Canadian Hospitals
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THE CHAIRMAN: I do not think we

need have any discussion on this because that principle
has been put forward. When you are saying it they should
have a defined legal status in Canada in hospitals
uniform to all of Canada?

DR. CASTLE: Yes.

THE CHAIRMAN: And how would you

propose that to be established having regard to the fact
that it is within provincial jurisdiction, the Dominion
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and with the provinces.

THE CHAIRMAN: But in terms of this

Commission, any recommendation this Commission might be



1 DR. CASTALDI: No, I do not have
2 any specific one at this time.

3 DR. MacLEAN: Mr. Chairman, is there
4 any merit in the fact that a policy can be recommended
5 by the Commission to be followed by various provinces?

6 THE CHAIRMAN: Well, if that is what
7 you mean.

8 DR. MacLEAN: I think that is what
9 we mean.

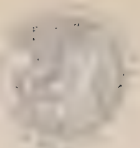
10 THE CHAIRMAN: That we could have a
11 look at it, give it thought in that direction, but I
12 thought I understood it to be said that this was sort of
13 a standard imposed from on high.

14 DR. MacLEAN: Well, I do not think so.

15 THE CHAIRMAN: Very well.

16 COMMISSIONER STRACHAN: May I ask
17 Dean MacLean where the term Dental Auxiliary (Alberta)
18 originates and the reason for it? It may be government
19 policy, I am not sure.

20 DR. MacLEAN: It is true to some
21 extent. We were trying to have the term dental hygienist
22 used, the curriculum they are trying is patterned after
23 the accepted standards set out by the council of dental
24 education of both the American and Canadian Dental
25 Associations for dental hygiene training. In setting up
26 this programme in Alberta there was some consideration
27 to extending the duties of these people and probably the
28 thought was to give them a distinctive name and in so
29 doing it was our recommendation from the first that these
30 people be called dental hygienists.



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any specific one at this time.

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MR. MACLENNAN: Well, I do not think so.

THE CHAIRMAN: Very well.

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this programme in Alberta there was some consideration

to extending the duties of these people and probably the

thought was to give them a distinctive name and in so

doing it was our recommendation from the fact that these

people be called dental hygienists.



1 COMMISSIONER STRACHAN: That is
2 truly a government term??

3 DR. MacLEAN: That is so.

4 THE CHAIRMAN: Dean MacLean, are you
5 in a position to say what the requirements of dentists
6 will be in Alberta in successive five or ten year periods
7 to 1981?

8 DR. MacLEAN: I think we have this
9 incorporated in the brief. We have, in paragraph 16 of
10 the brief, estimated our losses annually and from this
11 we have projected the requirements to 1971. We would
12 feel that we would require, in order to keep the percen-
13 tage of dentists per population to one in two thousand,
14 somewhere in the neighbourhood of 766 dentists.

15 THE CHAIRMAN: You say that you are
16 going to need 343 additional?

17 DR. MacLEAN: Yes.

18 THE CHAIRMAN: And that you would
19 hope to graduate 362 in that period?

20 DR. MacLEAN: Yes, considering the
21 losses of dentists and also considering the formation or
22 establishment of dental schools in other provinces.

23 THE CHAIRMAN: I want to deal with
24 this situation for a moment; is it a fair assumption that
25 Alberta is in perhaps a more fortunate position than
26 other places in that you are able to see a reasonably
27 adequate supply of dentists from your present facilities?

28 DR. MacLEAN: I believe this is so,
29 particularly that we are not charged with the responsi-
30 bility of training dentists for British Columbia and



That is

only a government report.

MR. MCELROY: That is so.

THE CHAIRMAN: Dean MacLean, are you

in a position to say what the requirements of dentists

will be in Alberta in successive five or ten year periods

to 1951?

MR. MCELROY: I think we have this

incorporated in the brief. We have, in paragraph 10 of

the brief, estimated our losses annually and from this

we have projected the requirements to 1951. We would

feel that we would require, in order to keep the current

rate of dentists per population to one in two thousand,

somewhere in the neighborhood of 700 dentists.

THE CHAIRMAN: You say that you are

going to need 300 additional?

MR. MCELROY: Yes.

THE CHAIRMAN: And that you would

hope to graduate just in that period?

MR. MCELROY: Yes, considering the

losses of dentists and also considering the formation of

establishment of dental schools in other provinces.

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this situation for a moment: is it a fair assumption that

Alberta is in perhaps a more fortunate position than

other places in that you are able to see a reasonably

adequate supply of dentists from your present facilities?

policy of training dentists for British Columbia and



1 Saskatchewan.

2 THE CHAIRMAN: You admitted fifty-
3 three to the first year in the fall of 1961?

4 DR. MacLEAN: That is right.

5 THE CHAIRMAN: How many of these were
6 from British Columbia?

7 DR. MacLEAN: Fifteen or sixteen.

8 THE CHAIRMAN: And from Saskatchewan?

9 DR. MacLEAN: I think there were
10 four or five from Saskatchewan.

11 THE CHAIRMAN: So that you have roughly
12 twenty of the fifty-three from outside Alberta?

13 DR. MacLEAN: That is so.

14 THE CHAIRMAN: Now, what is the
15 capacity of your school? Is fifty-three pretty well
16 capacity?

17 DR. MacLEAN: Yes, we can admit
18 somewhere between fifty and fifty-five per year. This,
19 of course, is limited by staff and other factors besides
20 physical facilities.

21 THE CHAIRMAN: And how many dentists
22 do you need from year to year now in terms of, say, five
23 years?

24 DR. MacLEAN: I think relatively we
25 can add about forty dentists per year to our numbers in
26 Alberta and that we can maintain our dentists ----

27 THE CHAIRMAN: What is the loss by
28 attrition and so on?

29 DR. MacLEAN: About thirteen per cent
30 now.



Saskatchewan.

THE CHAIRMAN: You admitted fifty-

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attrition and so on?



1 THE CHAIRMAN: Of 423?

2 DR. MacLEAN: Yes.

3 THE CHAIRMAN: And as your population
4 increases then you would want more dentists really because
5 of the population increase?

6 DR. MacLEAN: Yes.

7 THE CHAIRMAN: Would you care to
8 forecast how long you could continue to supply educational
9 facilities in dentistry to British Columbia and
10 Saskatchewan?

11 DR. MacLEAN: We would not expect
12 to be asked to supply dentists to British Columbia longer
13 than probably eight years more. Of course, we are not
14 the only source of supply of dentists in British Columbia,
15 but we do have from five to eight per class go to
16 British Columbia. These are generally residents that
17 return for practice.

18 THE CHAIRMAN: Some of these British
19 Columbia students may remain to practice in Alberta?

20 DR. MacLEAN: Some do.

21 THE CHAIRMAN: And the Saskatchewan
22 ones?

23 DR. MacLEAN: A good number of them
24 stay.

25 THE CHAIRMAN: So you cannot complain
26 very much about that?

27 DR. MacLEAN: No.

28 THE CHAIRMAN: You had 128 applications
29 in the fall of 1961?

30 DR. MacLEAN: Those are total



THE CHAIRMAN: OF 1933?

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increases then you would want more dentists really because

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1 applicants, not qualified applicants.

2 THE CHAIRMAN: From which you were
3 able to take fifty-three although fifty-six were academically
4 qualified?

5 DR. MacLEAN: We referred about three
6 to other schools.

7 THE CHAIRMAN: But by and large do you
8 seem to feel that your supply of applicants will be
9 reasonably adequate?

10 DR. MacLEAN: Reasonably so, sir.
11 We would hope probably to get a better academically
12 qualified applicant as we always do hope. We are, to use
13 an expression, probably still scraping the bottom of the
14 barrel a little bit in applicants, and with the activity
15 of the recruitment programmes we think probably this may
16 happen.

17 THE CHAIRMAN: Is the deficiency in
18 the ability of the applicant in the quality of his
19 formation up to that time?

20 DR. MacLEAN: It is generally in the
21 ability of the applicant because we do use his academic
22 performance as the gauge in admitting -- these applicants
23 failed to make the sixty-five per cent which is required
24 in their pre-dental education.

25 COMMISSIONER BALTZAN: Just this
26 comment: I want to say to you, Dr. MacLean, that your
27 brief is a very concise and a very comprehensive one.
28 Thank you very much.

29 COMMISSIONER STRACHAN: I think this
30 is the first time the Queen Elizabeth Education Scholar-



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14 barrel a little bit in applicant, and with the activity

15 of the recruitment program we think probably this may

16 happen.

17 THE CHAIRMAN: Is the tendency in

18 the ability of the applicant to the extent of the

19 formation up to that time?

20 DR. MACLEAN: It is generally in the

21 ability of the applicant and because we do use the academic

22 performance as the basis in admitting -- unless applicants

23 failed to make the thirty-five per cent which is required

24 in their pre-colonial education.

25 COMMISSIONER BALTIMORE: Just this

26 comment: I want to say to you, Dr. MacLean, that your

27 brief is a very concise and a very comprehensive one.

28 Thank you very much.

29 COMMISSIONER STRACHAN: I think this

30 is the first time the Queen Elizabeth Education Scholar-



1 ship Fund has been mentioned; could we get some facts
2 regarding that?

3 DR. McMURCHY: This is part of the
4 federal-provincial system in the Province of Alberta. I
5 believe it was named this when the Queen visited here so
6 that it has not had that title for very long. This refers
7 simply to the scholarship part of the whole system where
8 there are scholarships, grants and loans. The Queen
9 Elizabeth Education Scholarship Fund refers to the scholar-
10 ship branch of the whole system.

11 COMMISSIONER STRACHAN: How is it
12 utilized by forty-five per cent of the dental students?

13 THE CHAIRMAN: What page are you on?

14 COMMISSIONER STRACHAN: Page 11.

15 DR. McMURCHY: That refers to the
16 whole Student Assistance Act, and it is not too clear
17 there. Certainly the scholarship part -- that would
18 include scholarships, grants and loans.

19 COMMISSIONER STRACHAN: The forty-
20 five per cent?

21 DR. McMURCHY: Yes.

22 COMMISSIONER STRACHAN: And what would
23 amounts be to each individual?

24 DR. McMURCHY: Well, the Queen
25 Elizabeth Scholarships start at, I think there are three
26 hundred of them for the whole university, and it entitles
27 the student in the top three hundred of the university
28 whose average is over seventy-five to a scholarship of
29 \$100.00 if he can show need. He can then apply for
30 further assistance and that assistance sometimes comes



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22 amount to be for each individual?

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24 Elizabeth Scholarship award is, I think there are three

25 hundred of them for the whole university, and it entitles

26 the student in the top three hundred of the university

27 whose average is over seventy-five to a scholarship of

28 \$100.00 if he can show need. He can then apply for



1 to as much as \$1,200.00 if the student is needy. There
2 is a need factor inserted in there as well. For dental
3 students last year our dental students received about
4 \$7,500.00 in this form.

5 COMMISSIONER STRACHAN: How many
6 students?

7 DR. McMURCHY: I do not think I have
8 that figure. I am afraid I just do not have that figure
9 but I would assume about ten to twelve. However, I am
10 not sure, that is purely a guess.

11 THE CHAIRMAN: How many of these
12 scholarships or bursaries are contingent on return or
13 remaining in Alberta?

14 DR. McMURCHY: Actually none of these
15 are, there is no condition of that nature.

16 THE CHAIRMAN: You have no programme
17 of that kind?

18 DR. McMURCHY: I think it is fair to
19 say we have no programme of that nature.

20 DR. MacLEAN: Except in the dental
21 auxiliary programme which is based on that.

22 THE CHAIRMAN: Does the fact that
23 there is this condition of either return or employment
24 for a specified period, do you find that it inhibits the
25 situation in applying for such a bursary?

26 DR. McMURCHY: I think the province
27 of Saskatchewan and the province of Manitoba used to have
28 a system of this nature and while a good number of our
29 students have used this system there is a tendency not
30 to use it because of the return in service. I think that

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1 is a factor in the situation in accepting or not accept-
2 ing it.

3 THE CHAIRMAN: Even though they have
4 the option to pay back in any event?

5 DR. McMURCHY: Yes.

6 THE CHAIRMAN: To what extent would
7 you say there is that reluctance on the part of the
8 students to accept such a conditional bursary?

9 DR. McMURCHY: Well, I think that is
10 a very difficult question to answer and I am afraid I
11 have not had enough experience with it.

12 THE CHAIRMAN: Have you any views
13 either as to whether that type of thing should be continued
14 or discontinued?

15 DR. McMURCHY: In these other provinces?
16 We do not have this in Alberta.

17 THE CHAIRMAN: You have not got it
18 in Alberta?

19 DR. McMURCHY: No.

20 THE CHAIRMAN: I thought Dr. MacLean
21 said you had it.

22 DR. MacLEAN: In the dental auxiliary
23 programme which is a completely subsidized programme for
24 two years after which the individual is required to work
25 in a health unit for two years in return of service. This
26 only started recently, it is only one-year old and it
27 is difficult for us to say whether this would be a
28 deterrent or not. However, at the moment the applicants
29 are forced to accept this type of programme.

30 THE CHAIRMAN: What do you mean forced?

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28 deterrent or not. However, at the moment the applicants

29 are forced to accept this type of program.

30 THE CHAIRMAN: What do you mean forced?



1 DR. MacLEAN: I mean an applicant
2 cannot come into an university or was not able to go
3 last year and pay for his own tuition to take a hygiene
4 programme. The programme was only for students who were
5 subsidized.

6 THE CHAIRMAN: Why was that, because
7 there was only so many vacancies available?

8 DR. MacLEAN: To train these people
9 in the health units.

10 THE CHAIRMAN: Departmental personnel,
11 was that the idea?

12 DR. MacLEAN: That is true, and it
13 was more or less understood when this supply was satisfied
14 it would be opened up to people who might pay their own
15 tuition and thus have their training and be free to work
16 where they wouldst.

17 THE CHAIRMAN: Have you sensed any
18 opposition or any reluctance to thus work out; the fact
19 that they have to remain in Alberta for two years after
20 graduation?

21 DR. MacLEAN: Not that, but we had
22 a number of requests from a number of people who wished
23 to pay their own tuition to take the course.

24 THE CHAIRMAN: I am talking about the
25 other phase of it?

26 DR. McPHAIL: As far as the question-
27 aires that we have sent around to different students and
28 discussed with them this has not arisen.

29 COMMISSIONER STRACHAN: Did I under-
30 stand that they could buy themselves out?



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since that we have sent around to different students and

discussed with them this has not arisen.

COMMISSIONER STANHAM: Did I understand

stand that they could pay themselves out?



1 DR. MacLEAN: Not at the moment. The
2 way the act is set up they are required to work in the
3 health units for after graduation.

4 COMMISSIONER STRACHAN: For two years?

5 DR. MacLEAN: Yes.

6 COMMISSIONER STRACHAN: Then they may
7 go into private offices?

8 DR. MacLEAN: We think this, yes.

9 Actually it has not developed that far yet.

10 THE CHAIRMAN: Thank you very much,
11 Dean MacLean and gentlemen. This brief will have the
12 consideration of the Commission and we are grateful for
13 the assistance you have been to us.

14 DR. MacLEAN: Thank you very much,
15 sir.

16 THE CHAIRMAN: We will have a short
17 recess now.

18
19 --- Short recess.

20
21 SUBMISSION

22 of the

23 ALBERTA PHARMACEUTICAL ASSOCIATION

24
25 APPEARANCES:

26 MR. W. W. MADAY, President

27 MR. J. CAMERON, Registrar

28 DR. M. H. HUSTON, Dean of the Faculty
29 of Pharmacy

30 MR. G. R. FORSYTH, Counsel for Association



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16 MR. W. W. MADAY, President

17 DR. M. H. HUSTON, Dean of the Faculty

18 of Pharmacy

19 MR. G. R. FORSYTH, Counsel for Association



1 THE CHAIRMAN: We will proceed with
2 the submission of the Alberta Pharmaceutical Association.

3 THE SECRETARY: Exhibit 117.

4 The Office Consolidation of The Alberta
5 Pharmaceutical Act and By-laws will be 117A.

6
7 --- EXHIBIT NO. 117: Submission of the
8 Alberta Pharmaceutical
9 Association.

10 --- EXHIBIT NO. 117A: Office Consolidation of
11 The Alberta Pharmaceuti-
12 cal Act and By-Laws.

13 MR. MADAY: May I submit as an exhibit
14 a map depicting the electoral districts for representa-
15 tives on the Council of the Alberta Pharmaceutical
16 Association.

17 THE SECRETARY: 117B, sir.

18 MR. MADAY: And Mr. Chairman, the
19 Resource Handbook prepared in Alberta.

20 THE SECRETARY: 117C.

21
22 --- EXHIBIT NO. 117B: Map of the electoral
23 districts for represen-
24 tatives on the Council
25 of the Alberta Pharma-
26 ceutical Association.

27 MR. MADAY: And the calendar for the
28 Faculty of Pharmacy for the year 1961 and 1962, University
29 of Alberta.

30 THE SECRETARY: 117D.



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districts for representa-
tives on the Council
of the Alberta Pharma-
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EXHIBIT NO. 117B:

MR. MADAY: And the calendar for the

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of Alberta.



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--- EXHIBIT NO. 117C: Hospital Pharmacy
Resource Handbook

--- EXHIBIT NO. 117D: Calendar of the Faculty
of Pharmacy, University
of Toronto, 1961-62.

MR. MADAY: Mr. Chairman, I am Walter
W. Maday, president of the Alberta Pharmaceutical
Association.

With me, sir, I have Mr. John Cameron,
the registrar of the Association; Dr. M. H. Huston, Dean
of the Faculty of Pharmacy and our counsel, Mr. G. R.
Forsyth.

Members of the Commission, if I may
read the summary and the recommendations of this brief.

SUMMARY AND RECOMMENDATIONS

The brief of the Alberta Pharmaceutical
Association is presented in four parts.

A. In part I is discussed the origin of the
Association and a legal description of the Act which
controls the registration, training requirements and
professional performance of pharmacists in the province of
Alberta.

B. Federal legislation which affects the
practice of pharmacy is cited.

C. A quantitative appraisal of personnel
is included. This is enlarged upon in appropriate areas



1 of the brief.

2 D. Part II is a statement of principles.

3 The Alberta Pharmaceutical Association brief endorses the
4 statement of policy of the Canadian Pharmaceutical
5 Association.

6 E. The desire of the members of the Alberta
7 Association to co-operate in any method whereby health
8 services can be improved is stated.

9 F. It is believed that it is a pharmacist's
10 responsibility to assure that any health plan should
11 include effective and complete pharmaceutical service.

12 G. It is submitted that the provision of
13 Pharmaceutical service can best be made available through
14 the existing privately owned and operated pharmacies.

15 H. The brief maintains that those who are
16 able to pay for their pharmaceutical services should
17 continue to do so. Attention is invited, from all con-
18 cerned, for those who may need assistance.

19 Part III outlines the provision of
20 pharmaceutical services in this province.

21 I. The provision of pharmaceutical services
22 is detailed as it is found in retail and hospital pharmacies.

23 J. The brief suggests that the present
24 retail distributive network provides an excellent
25 availability for pharmaceutical services to the citizens
26 of this province.

27 K. An attempt has been made to calculate
28 an annual average per-person cost of prescribed medicines
29 through retail pharmacies. This figure is calculated
30 to be \$8.69.



1 L. It is suggested that some of those
2 whose requirements are in excess of the average may have
3 difficulty in providing pharmaceutical benefits for
4 members of their families. On a priority basis, in order
5 of need, the groups which may require assistance are
6 described.

7 M. The brief deals with hospital pharmacy
8 and recommends that a registered pharmacist be retained
9 to provide pharmaceutical services in hospitals of all
10 sizes.

11 N. Other methods of present drug distribu-
12 tion are reported. In this connection the brief
13 recommends wherever drugs are to be dispensed that the
14 service be under the supervision of a pharmacist and that
15 the professional responsibility be upon such person.

16 Part IV deals with Education and
17 Research.

18 O. A short history of pharmaceutical
19 education in Alberta is presented.

20 P. The curriculum is outlined. Students
21 may:-(1) take a three year course beyond Senior
22 Matriculation leading to the B.Sc. degree in Pharmacy,
23 which is the minimum requirement for licensure or (ii)
24 elect to continue to a fourth year of specialization in
25 Retail Pharmacy, Hospital Pharmacy or Pharmaceutical
26 Science and be awarded with Honors or Major in the area
27 of specialization.

28 Q. The enrolment over the past 19 years
29 is recorded and the increased number of women students
30 is noted.



1 R. The recommendation of the Canadian
2 Pharmaceutical Association for a manpower survey is
3 supported to obtain data to assist the colleges in plan-
4 ning for the future.

5 S. The activities of the Faculty in
6 research and graduate studies are described.

7 T. The Commission is urged to encourage
8 financial support of research in the health sciences in
9 the universities.

10 THE CHAIRMAN: Thank you, Mr. Maday.

11 Now, do any of your associates wish to
12 say anything further at this time?

13 MR. MADAY: I don't think so.

14 THE CHAIRMAN: Because of an incident
15 that happened at the conclusion of the last presentation,
16 I want to make it clear that if before you leave the
17 table somebody has something they would like to say,
18 feel absolutely free to say it. We want you to do so.
19 We can't anticipate what ideas you may have and put
20 questions to you regarding them, however long our questioning
21 may be. We may even come to the point where we might
22 have no questions to ask.

23 Now, your summary and recommendations,
24 No. F on the preface, on the first page:

25 "F. It is believed that it is a
26 pharmacist's responsibility to assure that
27 any health plan should include effective and
28 complete pharmaceutical service."

29 What is the view of your association
30 toward the pre-paid plans of drug, for drug coverage?



1 MR. MADAY: We feel a pre-paid
2 prescription plan would be most desirable, sir. It would
3 be very helpful.

4 THE CHAIRMAN: How do you foresee
5 that such a plan could be formulated?

6 MR. MADAY: This plan, Mr. Chairman,
7 could be formulated on existing carriers if it met with
8 the approval of the pharmacists.

9 THE CHAIRMAN: Existing carriers,
10 you mean M.S.I.?

11 MR. MADAY: M.S.I. or others.

12 THE CHAIRMAN: You believe if it was
13 adjunct, I suppose, a department?

14 MR. MADAY: If there was a represen-
15 tative in there, on a proper, on a good arrangement with
16 them, then we would be happy.

17 THE CHAIRMAN: So you would have one
18 agent administering the fund, the health service fund
19 rather than a group?

20 MR. MADAY: That is correct.

21 THE CHAIRMAN: That is your view.
22 Thank you very much for it.

23 COMMISSIONER McCUTCHEON: You would
24 have no objection to a commercial carrier issuing a policy
25 that might provide for pre-paid drug coverage?

26 MR. MADAY: Provided it isn't money
27 making.

28 COMMISSIONER McCUTCHEON: It is
29 implicit in my question. It would be money making. It
30 is a commercial carrier.



1945

Today

MR. MADAY: We feel a free-charge

contribution plan would be most desirable.

How do you foresee

that such a plan could be implemented?

MR. MADAY: This plan, Mr. Chairman,

could be implemented on existing contracts if it is with

the approval of the pharmaceutical

MR. CHAIRMAN: Existing contracts,

you mean U.S.I.?

MR. CHAIRMAN: You believe it is

urgent, I suppose, to begin work

MR. MADAY: If there was a respon-

sive in the U.S. on a proper, on a good arrangement with

then, that would be better.

MR. CHAIRMAN: Do you want some one

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have no objection to a commercial carrier issuing a policy

that might provide for pre-paid drug coverage?

MR. MADAY: Provided it isn't money

making.

MR. CHAIRMAN: It is

difficult in my opinion. It would be money making.

It is a commercial carrier.



1 MR. MADAY: If it caused conflict,
2 I would say no.

3 THE CHAIRMAN: Would you speak up
4 just a little louder because as I mentioned earlier the
5 acoustics in the room are not the best.

6 Paragraph K on page 2, that figure
7 which is calculated, \$8.69 per person cost of prescribed med-
8 cines through retail pharmacies. Is it implicit in that
9 that you have excluded all drugs, all prescribed drugs
10 furnished through hospital pharmacies?

11 MR. MADAY: No, sir, our calculations
12 were based on a survey which was carried out through some
13 seven areas of the province of Alberta, through retail
14 pharmacies. These pharmacies were made up of represen-
15 tatives of professional pharmacies, pharmacies in down-
16 town locations, pharmacies in outlying areas, small towns,
17 that is, towns that have one or two pharmacies or more,
18 and towns that have only one pharmacy.

19 THE CHAIRMAN: Did they include
20 hospital pharmacies?

21 MR. MADAY: No, sir.

22 THE CHAIRMAN: Or the pharmacies in
23 the provincial institutions or mental institutions?

24 MR. MADAY: No, it didn't, sir.

25 THE CHAIRMAN: So there would have
26 to be a figure of cost added to the \$8.69 to arrive at
27 what might be the provincial per capita cost?

28 MR. MADAY: That is correct, sir, yes.

29 THE CHAIRMAN: Now, in L, you say,
30 and I am paraphrasing for a moment on the matter of

MR. MADAY: That is correct, sir, yes

what might be the provincial per capita costs?

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that is, towns that have one or two pharmacies or more,

four locations, one located in outlying areas, small towns,

assess of provincial pharmacies, passed on down

pharmacies. These pharmacies were made up of represen-

seven areas of the province of Alberta, through retail

were passed on a survey which was carried out through some

MR. MADAY: No, sir, one calculation

furnished through hospital pharmacies?

that you have excluded all drugs, all pharmacy drugs

to be included in that

which is calculated, \$8.69 per person cost of prescribed

Paragraph K on page 2, last figure

accounted in the year are not too great.



1 providing prescribed drugs to those who cannot purchase
2 them, you say, on on priority basis in order of need
3 the groups which may require assistance are described.
4 Would you just elaborate on that. I know you have
5 described it in paragraph 25.

6 MR. MADAY: It refers to page 6,
7 paragraph 25, Mr. Chairman, about four lines from the
8 bottom. It is suggested that there are those who need
9 some assistance all of the time, and those who need some
10 assistance some of the time. We believe that in order
11 of need, such groups would be described as: indigents,
12 senior citizens who receive a supplementary provincial
13 allowance in addition to the federal government pension,
14 widows, blind pensioners; those who are afflicted with
15 certain chronic diseases; those who might be confronted
16 with catastrophic drug costs; and finally, the low income
17 group.

18 THE CHAIRMAN: Of that five which
19 do you put in the first category and which in the second?

20 MR. MADAY: In the order in which
21 they appear.

22 THE CHAIRMAN: Where is your division?
23 You say some need it all the time and some only part of
24 the time.

25 MR. MADAY: After three is where we
26 have some doubt, I think, Mr. Chairman.

27 THE CHAIRMAN: Those you would pro-
28 vide on a basis of need?

29 MR. MADAY: That is right.

30 THE CHAIRMAN: How would you determine



1 these?

2 MR. MADAY: I don't think we would
3 be the ones to judge who needs it. I think there are
4 agencies established that could determine this.

5 THE CHAIRMAN: You don't suggest
6 being able to deal with that at all?

7 MR. MADAY: Not as pharmacists, no.

8 THE CHAIRMAN: If some other agency
9 said so and so is in this category?

10 MR. MADAY: That is correct, sir.

11 THE CHAIRMAN: You would accept that?

12 MR. MADAY: Yes.

13 THE CHAIRMAN: The M:

14 "The brief deals with hospital pharmacy
15 and recommends that a registered pharmacist
16 be retained to provide pharmaceutical services
17 in hospitals of all sizes."

18 What are your smallest hospitals in
19 Alberta?

20 MR. MADAY: Under twenty-five beds,
21 about ten beds, ten to twenty-five.

22 THE CHAIRMAN: Are you recommending
23 the employment of a registered pharmacist in a ten-bed
24 hospital?

25 MR. MADAY: Not in that way.

26 THE CHAIRMAN: On what basis?

27 MR. MADAY: If there is a pharmacist
28 in the area or in the district they could go and serve
29 that district rather than having some one on staff.

30 THE CHAIRMAN: How would you employ



100-10000

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THE CHAIRMAN: You would accept that?

MR. MADAY: Yes

THE CHAIRMAN: All right.

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THE CHAIRMAN: On what basis?

MR. MADAY: It there is a pharmacist

in the area or in the district they could go and serve

that district rather than having some one on staff?

THE CHAIRMAN: How would you employ



1 him, on salary, part-time salary, fee for service?

2 MR. MADAY: On hospitals we visua-
3 lize it to be a salary basis. We couldn't go on a fee
4 for service basis in a hospital.

5 THE CHAIRMAN: Have you arrived at
6 a figure, that is, in terms of size, bed size of the
7 hospital, you would recommend employment of a full-time
8 pharmacist?

9 MR. MADAY: Yes. The fact is the
10 hospitals between the capacity of seventy-five to one
11 hundred beds could easily maintain a full-time pharmacist
12 to carry out the duties that he would be responsible for.

13 THE CHAIRMAN: What is the practice
14 in Alberta today?

15 MR. MADAY: There are only eighteen
16 hospitals in Alberta that utilize the service of a
17 pharmacist and the majority of these are in the large
18 institutions. There are very little in the small hospitals.

19 THE CHAIRMAN: How then are the
20 pharmaceuticals handled in smaller hospitals that have
21 no registered pharmacist?

22 MR. MADAY: They are handled -- we
23 are given the impression they are handled by matrons
24 under the jurisdiction of the local doctor in that
25 hospital. They are not handled by pharmacists.

26 THE CHAIRMAN: Has there been any
27 discussion with the Department of Health regarding the
28 employment of registered pharmacists in these hospitals
29 where they are not now employed?

30 MR. MADAY: Yes, it has been



1 discussed with them and since this is an area the
2 government feels that the hospitals should establish
3 their own level of service, they feel it is up to the
4 hospitals to determine whether they require a pharmacist
5 or not.

6 We had negotiated -- I should say had.

7 THE CHAIRMAN: Before you go on,
8 just that point, do you mean they told you it is up to
9 the hospital to employ or not to employ a pharmacist as
10 the hospital may see fit as a budgetary item or at the
11 expense of the hospital?

12 MR. MADAY: This has not been
13 clearly defined. If the hospital has expressed, at least
14 we are told, if the hospital expresses desire to have a
15 pharmacist then the Department of Health will decide
16 whether they will approve it or not approve it.

17 THE CHAIRMAN: Where it becomes part
18 of a possible deficit?

19 MR. MADAY: That is correct.

20 THE CHAIRMAN: The College of
21 Pharmacy in Alberta graduated how many pharmacists in
22 the spring of 1961, Dr. Huston?

23 DR. HUSTON: Sixty.

24 THE CHAIRMAN: Is that regarded as
25 a reasonable number for the province of Alberta? Will
26 that seem to fill the needs of the province?

27 DR. HUSTON: I cannot answer that
28 in detail, sir. I know they all found opportunities
29 very promptly. That is one of the reasons why we have
30 recommended that a manpower survey be made in pharmacy



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 government feels that the hospitals should establish
 their own level of service, they feel it is up to the
 hospitals to determine whether they require a pharmacist
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 the spring of 1961, Mr. Hadley?

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 that seem to fill the needs of the province?

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 very promptly. That is one of the reasons why we have
 recommended that a temporary reserve be made in pharmacy



1 to give us a better indication as to whether we are
2 satisfying the demand adequately, inadequately, and what
3 the future may hold.

4 THE CHAIRMAN: Has the Pharmaceutical
5 Association made any such manpower survey in Alberta?

6 DR. HUSTON: No.

7 MR. MAYDAY: No, we haven't, sir.

8 DR. HUSTON: It is complicated, sir,
9 by the fact pharmacists are going into areas other than
10 retail pharmacy including hospital pharmacy, going into
11 industry, going on to graduate work, to research, to
12 joining companies, in various capacities, and this type
13 of development is continuing and will continue to
14 develop from all indications, so it is difficult to make
15 such an estimate without a rather thorough look into
16 what the graduates will do in the future.

17 THE CHAIRMAN: Have you any informa-
18 tion or view to offer on the question of the utilization
19 of your registered pharmacists, that is, how much of
20 his time is he being a pharmacist, and how much is he
21 being a retail merchant, or something like this?

22 DR. HUSTON: This, again, we have
23 no definite figures on. In some places, as in hospitals,
24 and in those pharmacies that are devoting themselves
25 entirely to dispensing, they would be using all of their
26 time on straight professional matters. In other areas,
27 a lower percentage of their time would be devoted
28 entirely to professional matters. We have no survey made
29 as to what the over-all picture is, sir.

30

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1 THE CHAIRMAN: Are you in a position
2 to give us any information as to the number of pres-
3 criptions, that is, for prescribed drugs, which are
4 compounded in the pharmacy as distinct from previously
5 prepared drugs provided by prescription?

6 MR. HUSTON: There have been various
7 figures quoted in the literature, sir.

8 THE CHAIRMAN: No, in Alberta, first,
9 and then I will take your answer.

10 MR. MADAY: No, we do not have, sir,
11 but in this survey we did on these seven centres, as I
12 had outlined, Mr. Chairman, we had asked for and did
13 obtain a survey on 3,491 prescriptions, and out of this
14 group the only thing that we were able to find -- and
15 that is that 3,119 prescriptions were written for brand-
16 name products, which is roughly 89.34 per cent of the
17 total.

18 THE CHAIRMAN: Now, that means that
19 the pharmacist did not change the nature of the product?

20 MR. MADAY: That is right.

21 THE CHAIRMAN: He took it from one
22 container to another?

23 MR. MADAY: That is correct. And
24 then, we had 243 prescriptions that were written using
25 generic terminology, or, 6.69 per cent.

26 THE CHAIRMAN: Now, what is involved
27 there? Is there a matter of judgment involved in the
28 selection by the pharmacist of what he is going to give
29 the patient?

30 MR. MADAY: Yes. In other words,



1 by the use of generic, I can turn to my stocks on the
2 shelf and I might have a choice of two or three products
3 from which I can chose the one I then dispense.

4 THE CHAIRMAN: For that you need your
5 training as a pharmacist?

6 MR. MADAY: That is right, sir, and
7 then there were 129 prescriptions required in the
8 compounding of prescriptions in the pharmacy, or, 3.97
9 per cent. This survey was not taken in any specific
10 areas.

11 I think that the figure can be complete
12 when you go, perhaps, to areas where there is a
13 dermatologist, and you might find that way a high
14 percentage of compounded prescriptions. This was taken
15 on not a slanted look, but just as a parcel.

16 THE CHAIRMAN: You were trying to
17 make an objective survey?

18 MR. MADAY: That is right. These
19 figures were presented to the Restrictive Trade Practices
20 Commission, and if you would like us to file this, we
21 will.

22 THE CHAIRMAN: It would be helpful
23 if you would.

24
25 --- EXHIBIT NO. 117E: Submission of the
26 Alberta Pharmaceutical
27 Association to the
28 Restrictive Trade Practices
29 Commission relating to
30 the Manufacture, Distribution and Sale of Drugs.



from which I can choose the one I then dispense.

THE CHAIRMAN: For that you need your

training as a pharmacist?

MR. MADAY: That is right, sir, and

then there were 189 prescriptions rendered in the

compounding of prescriptions in the pharmacy, or, 3.9

per cent. This survey was not taken in any specific

area.

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when you go, perhaps, to areas where there is a

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EXHIBIT NO. 11 E

Submission of the

Alberta Pharmaceutical

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Restrictive Trade Practices

Commission relating to

the Manufacture, Distrib-



1 THE CHAIRMAN: Is this a question
2 which can be answered with any value, as to whether a
3 greater utilization might be made of the number of
4 registered druggists --- a greater utilization in point
5 of that pharmacist's time than is done at the present
6 time, where as we know the corner drug store is pharmacy-
7 plus?

8 MR. MADAY: Yes, certainly. In
9 hospitals, definitely.

10 THE CHAIRMAN: No, but I mean
11 generally. I mean to say in the ---

12 MR. MADAY: May I have your question
13 again, sir?

14 THE CHAIRMAN: Well, you may have,
15 say, in the smaller city eight or ten corner drug stores,
16 you know, with a pharmacist in each one being available
17 in his store throughout the whole day, but only, say,
18 using a quarter or a third of his time as a pharmacist.

19 Is there any solution to that wastage
20 of pharmacists' manpower for making him a general
21 merchant and not a pharmacist?

22 MR. MADAY: Well, under our free-
23 enterprise system, sir, I can see no different method
24 than what is being done now. He is providing a service
25 in an area, and he is relying on the front store to
26 enable the service to be given in that particular area.

27 THE CHAIRMAN: Now, you see that
28 poses this question: What is the obligation of the state
29 to increase the number of pharmaceutical colleges,
30 pharmacy colleges, and so forth, if we are going to



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entirely correct, but I can see no different method

than what is being done now. He is providing a service

in an area, and he is relying on the fact that he

enable the service to be given in that particular area.

THE CHAIRMAN: Now, you see that

raises this question: What is the obligation of the state

to increase the number of pharmaceutical colleges,



1 distribute the graduate pharmacists over a great area
2 where he may only be using an hour a day as a pharmacist?

3 MR. CAMERON: I would think, Mr.
4 Chairman, that this would be rather a narrow confine.
5 The fact that a man is not dispensing prescriptions does
6 not necessarily mean that he is not exercising his
7 professional skill and judgment in the management of his
8 pharmacy's affairs.

9 I would not be in a position to quarrel
10 with anyone on any suggested figure, but I would think
11 that an hour a day would be a very, very low figure.

12 THE CHAIRMAN: I do not want to
13 quarrel with that. I do not suggest it as a figure with
14 any foundation. I might as well have said ten minutes
15 or six hours a day. I was only referring to the period
16 of time short of full-time.

17 MR. HUSTON: If I may speak to that
18 point, sir. I am chairman of a committee that will be
19 preparing a brief, so I shall have the pleasure of seeing
20 you gentlemen again on behalf of the Pharmaceutical
21 Faculties which appears for all the pharmaceutical
22 colleges in Canada. We shall be speaking on this plan
23 in more detail, and shall be making certain suggestions
24 as to how there might be greater utilization of
25 pharmaceutical manpower.

26 THE CHAIRMAN: That is very well.
27 We will wait then, until we hear from you.

28 COMMISSIONER VAN WART: No. 40 on
29 page 10, the fourth section: The government of Alberta
30 supplies certain drugs without charge, and drugs if



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15 of time spent of each day.

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28 page 10, the fourth section: The Government of Alberta
29 supplies certain drugs without charge, and drugs at



1 required for tuberculosis treatment after discharge from
2 hospital. I notice no where in the list about psychiatric
3 patients when they leave the mental hospitals.

4 Are those drugs supplied similar to
5 tuberculosis drugs?

6 MR. MADAY: I do not know, sir. We
7 do not know, and I believe they do not.

8 COMMISSIONER VAN WART: They do not?

9 MR. MADAY: I might be wrong on that.

10 COMMISSIONER VAN WART: That is all,
11 sir.

12 MR. MADAY: Dr. Van Wart, if this
13 would help, this is the list that we had received from
14 the College of Physicians and Surgeons. Perhaps they
15 could elaborate on it.

16 COMMISSIONER VAN WART: We will have
17 a chance when the psychiatric people appear. Thank you.

18 COMMISSIONER BALTZAN: I see in
19 item K an attempt has been made to calculate the annual
20 average per person costs of prescribed medicines, and you
21 gave us a figure. Is that per person or per patient
22 cost?

23 MR. MADAY: That is per person.

24 COMMISSIONER BALTZAN: You mean the
25 population in Alberta, or the sick population?

26 MR. MADAY: It is per person, Dr.
27 Baltzan.

28 COMMISSIONER BALTZAN: If it is per
29 person, or per individual sick person, it would become
30 a great deal more; wouldn't it?



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27 Hallman.
28 COMMISSIONER HALLMAN: If it is per
29 person, or per individual sick person, it would become
30 a great deal more; wouldn't it?



1 MR. MADAY: Yes.

2 COMMISSIONER BALTZAN: So that the
3 burden could be considered as considerably increased to
4 the people who have to take medicine, because they are
5 sick for a long time, and if they are expensive?

6 MR. MADAY: That is right, yes.

7 COMMISSIONER BALTZAN: So this is
8 per person and not per patient?

9 MR. MADAY: Per person, yes.

10 COMMISSIONER BALTZAN: Thank you then.

11 In view of the reduction in the number
12 of compounded prescriptions, could the pharmacist handle
13 many more prescriptions per day, say, in former times
14 when there was less packaging as there is today -- numbers
15 of prescriptions?

16 MR. MADAY: Yes. The compounding
17 time would be decreased; consequently, he would have more
18 time for his other efforts, yes. He could handle a
19 greater volume.

20 COMMISSIONER BALTZAN: And that sort
21 of thing helps take care of the shortage of pharmacists
22 or is, in a measure, somewhat compensatory?

23 MR. MADAY: That is right, sir.

24 COMMISSIONER BALTZAN: With regard
25 to the use of generic names and trade names, do you think
26 that the preference for the use of generic names versus
27 trade names is one of preference on the part of the
28 physician? If he wants to consider mainly the cost, he
29 would concentrate on just writing the generic name?

30 MR. MADAY: Yes.



1 COMMISSIONER BALTZAN: But he
2 should consider that, but, on the other hand you find
3 he uses the trade name more often. Do you think that is
4 because he remembers the trade name more quickly?

5 THE CHAIRMAN: If your question is
6 to be of value to the rest of us, Commissioner Baltzan
7 -- is it a fact that more prescriptions are stated to be
8 trade-name rather than generic?

9 COMMISSIONER BALTZAN: Yes, but also,
10 Mr. Chairman ----

11 THE CHAIRMAN: Let us deal with one
12 step at a time.

13 MR. MADAY: I would feel that the
14 brand-name is the preferable name.

15 THE CHAIRMAN: No. What is your
16 experience? What are the doctors in Alberta doing? Are
17 they prescribing brand or generic names, and in what
18 proportion?

19 MR. MADAY: Fifteen to one for brand-
20 names.

21 COMMISSIONER BALTZAN: Thank you
22 for helping me out.

23 And the reason for that --- would it
24 be because the trade-name is easier to remember rather
25 than the generic name?

26 MR. MADAY: It could very well be,
27 Dr. Baltzan, but I am afraid that the practising
28 physician or surgeon would have to answer that question
29 as to why he personally feels that way.

30 COMMISSIONER BALTZAN: But you would



COMMISSIONER BARTMAN: But he

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COMMISSIONER BARTMAN: Thank you

for that, Mr. Maday.

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be because the trade-name is easier to remember rather than the generic name?

MR. MADAY: It could very well be.

Dr. Bartman, but I am afraid that the practicing physician or surgeon would have to answer that question as to why he personally feels that way.

COMMISSIONER BARTMAN: But you would



1 have an idea?

2 MR. MADAY: Yes, I would have.

3 THE CHAIRMAN: And your idea is ---

4 now that it has been suggested to you by Dr. Baltzan --

5 I am sure they would not mind you expressing it.

6 MR. MADAY: My personal idea is that

7 they prefer the brand-name.

8 THE CHAIRMAN: And it is not because

9 they are too lazy to-remember the long name?

10 COMMISSIONER McCUTCHEON: Maybe they

11 do not remember the long name.

12 MR. MADAY: I am afraid they do, sir.

13 I had better go on record on that one.

14 THE CHAIRMAN: In other places we

15 have been told of drug stores being owned or controlled

16 by doctors to which they direct the patient with the

17 prescription and in such a way that that is where the

18 prescription is going to be filled; have you any such

19 situation in Alberta?

20 MR. MADAY: No. This does not exist

21 widespread. There is only one or two or three that the

22 doctors do have some interests in. This is not a common

23 practice here in Alberta.

24 THE CHAIRMAN: When you say one or

25 two or three --

26 MR. CAMERON: There is no experience

27 of any code numbers as of 1962.

28 MR. MADAY: I believe in some smaller

29 towns the doctor and pharmacist do have a relationship

30 due to the fact that the doctor does have an ownership

1
2
3 THE CHAIRMAN: And your idea is --
4 now that it has been suggested to you by Dr. Berman
5 I am sure they would not mind you expressing it.
6 MR. WADSWORTH: My personal idea is that
7 they prefer the brand-name.
8 THE CHAIRMAN: And it is not because
9 they are too busy to remember the long names?
10 MR. WADSWORTH: Maybe they
11 do not remember the long names.
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13 I had better go on record on that one.
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15 have been told of drug stores being owned and controlled
16 by doctors at which they directed the patients with the
17 prescription and in such a way that that is where the
18 prescription is going to be filled; have you any such
19 situation in mind?
20 MR. WADSWORTH: No, I do not think so.
21 I think there is only one or two or three that the
22 doctors have some interest in. This is not a common
23 practice here in Alabama.
24
25 two or three --
26 MR. WADSWORTH: There is no experience
27 of any large number as of 1941.
28 MR. WADSWORTH: I believe in some cases.



1 in the store.

2 COMMISSIONER BALTZAN: But the
3 patient can still take that prescription to the next town
4 and get it filled?

5 MR. MADAY: Oh, yes, certainly.

6 THE CHAIRMAN: As I understood from
7 what you were saying, Mr. Cameron, that there was no
8 coding of prescriptions so that it could only be filled
9 at an identified drug store?

10 MR. CAMERON: Such a complaint has
11 not come to our attention for a number of years, and I
12 would say there is not one instance of it in 1962.

13 THE CHAIRMAN: I mean, it is not a
14 factor here?

15 MR. CAMERON: No.

16 COMMISSIONER FIRESTONE: Mr. Chairman,
17 if I may follow up the questions you have raised on pre-
18 payment.

19 I understand later that you said that
20 you would be in favour of a pre-paid drug plan?

21 MR. MADAY: That is correct, sir.

22 COMMISSIONER FIRESTONE: Now, would
23 you feel that if such a plan were instituted there would
24 be a need for a deterrent fee for prescribed drugs, and
25 I may perhaps refresh your memory or perhaps suggest to
26 you that we asked a similar question to the physicians
27 who appeared as witnesses before, and they expressed the
28 view they would not be in favour of a major deterrent.

29 How do the pharmacists feel on the same
30 subject in their own field?



and now it filled

MR. WATKINS:

As I understood from

what you were saying, Mr. Gannett, that there was no
evidence of any other persons so that it could only be filled

at an identified drug store?

MR. WATKINS: Such a complaint has

not come to my attention for a number of years, and I

would say that is one instance in 1962.

THE CHAIRMAN: I mean, it is not a

factor here?

if I may finish up the question you have raised or pre-

sumed.

I think and I am sure that you said that

you would be in a way of a good drug store?

MR. WATKINS: That is correct, sir.

You told me that if such a plan were introduced there would
be a need for a large stock of the restricted drugs, and
I may perhaps correct your memory or perhaps suggest to
you that we asked a similar question to the physicians
who appeared as witnesses before, and they expressed the
view they would not be in favour of a major deterrent.

How do the pharmacists feel on the same

subject in their own field?



1 MR. MADAY: We feel that if it is
2 necessary to have a deterrent, then we would like to see
3 it come right on from the start rather than add it on.
4 It appears from experience in other countries that a
5 deterrent is necessary.

6 Now, we do not know -- we ourselves
7 cannot express that. If it is necessary then, it should
8 go on at the first.

9 COMMISSIONER FIRESTONE: May I now
10 turn, sir, to the question of drug prices. You understand,
11 sir, that this subject of drug prices being high has
12 been presented to us over and over again. This
13 Commission is not in a position at this point to have any
14 views on the subject, whether they are high or low.

15 We are trying to ascertain what are
16 some of the factors that contribute to this. We are,
17 therefore, interested in the factors contributing to cost
18 rather than the judgment whether they are high or low.
19 This judgment may come later, but at the moment, we are
20 just trying to get at the facts.

21 Now, sir, how is the retail price of
22 a drug determined by a pharmacist?

23 MR. MADAY: The retail price deter-
24 mined by the pharmacist is based on the average which he
25 experiences in his store -- the average costs which he
26 experiences in his store. Statistics -- surveys is a
27 better word I should use there. Surveys have shown that
28 the pharmacist requires a forty per cent margin from
29 which to operate; and that this margin -- taking this
30 margin into account, the pharmacist takes the forty per

necessary to have a different, then we would like to see
it some right on from the point rather than add it on.
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COMMISSIONER WILSON: May I now

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that, first, the point of drug prices being high has
been mentioned to us over and over again. This

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experiences in his store. Statistics -- surveys is a

matter which I should use there. Surveys have shown that
the pharmacist requires a forty per cent margin from
what he operates; and that this margin -- taking this
margin into account, the pharmacist takes the forty per



1 cent and adds on a small professional fee in order to
2 establish proper evaluation to him for the prescription.

3 COMMISSIONER FIRESTONE: Now, sir,
4 I understand that the costs to the purchaser is made up
5 ~~on the~~ laid down cost of the distributor, the price you
6 pay, your transportation, etcetera, plus two additional
7 charges: dispensing fee and mark-up. How high is the
8 dispensing fee?

9 MR. MADAY: Dispensing fee is on this
10 basis: Mark-up forty per cent. Our dispensing fee is
11 seventy-five cents.

12 COMMISSIONER FIRESTONE: Seventy-five
13 cents?

14 MR. MADAY: Seventy-five cents on
15 unbroken quantity. On a broken quantity, we take one
16 dollar.

17 COMMISSIONER FIRESTONE: It is seventy-
18 five cents on an unbroken quantity, and a dollar on a
19 broken quantity?

20 MR. MADAY: Yes.

21 COMMISSIONER FIRESTONE: This is a
22 flat rate applicable to a drug that costs fifty cents or
23 ten dollars?

24 MR. MADAY: That is correct, sir.

25 COMMISSIONER FIRESTONE: Who sets
26 this dispensing fee?

27 MR. MADAY: The pharmacist that is
28 dispensing. The average fee as stated is seventy-five
29 cents or one dollar.

30 COMMISSIONER FIRESTONE: Does the



1 association set it, or does each pharmacist set it because
2 he considers this fee is reasonable? In other words,
3 are there variations in the dispensing fee?

4 MR. MADAY: There are variations in
5 the dispensing fee, yes, but the majority have stayed
6 with the seventy-five cents and one dollar.

7 COMMISSIONER FIRESTONE: What are
8 some of the dispensing fees charged by the minority?

9 MR. MADAY: Some do not charge any
10 dispensing fee; some charge fifty cents, and some do not
11 go to a dispensing fee.

12 They state it in this manner: Costs
13 plus a professional fee. Costs, which we have not been
14 able to really justify, and we believe in this cost they
15 show cost, container cost, plus a mark-up, plus a dollar.
16 This is something which an individual varies in the way
17 in which he wishes himself.

18 COMMISSIONER FIRESTONE: Do you know
19 of cases where a dispensing fee is higher than the one
20 dollar?

21 MR. MADAY: Yes -- I personally do
22 not know it.

23 COMMISSIONER FIRESTONE: Do any of
24 your colleagues?

25 MR. CAMERON: Yes, I do, \$2.00.

26 COMMISSIONER FIRESTONE: Now can we
27 come to this mark-up?

28 MR. CAMERON: Before we leave that,
29 if I may, the one instance I know that uses this formula
30 does not have a profit motive, it does not enter into the



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your colleagues?

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come to this mark-up?

MR. MADAY: Before we leave that,

does not have a profit motive, it does not enter into the



1 profit motive, it is the cost plus \$2.00 so there is no
2 profit motive added in.

3 THE CHAIRMAN: You mean no mark-up?

4 MR. CAMERON: No mark-up.

5 COMMISSIONER FIRESTONE: In other
6 words, it would mean that for a high priced drug the
7 purchaser gets a bargain and for a low priced drug he
8 pays more than he would pay in another drug store?

9 MR. MADAY: In essence that is
10 correct. In essence the forty per cent mark-up is part
11 of our professional fee.

12 COMMISSIONER FIRESTONE: If I may
13 turn to the mark-up question, is it forty per cent of the
14 list price or forty per cent of the cost price?

15 MR. MADAY: Forty per cent of the list
16 price.

17 COMMISSIONER FIRESTONE: In other
18 words, if we had a drug that lists at one dollar your
19 mark-up would be forty cents and your cost would be sixty
20 cents?

21 MR. MADAY: That is correct.

22 COMMISSIONER FIRESTONE: Therefore
23 forty per cent as a percentage of the sixty cents would
24 represent a mark-up of $66 \frac{2}{3}$ per cents of cost, is that
25 correct?

26 MR. MADAY: On that premise, yes.

27 COMMISSIONER FIRESTONE: We are trying
28 to establish whether mark-up is based on cost or on list.
29 Usually mark-ups are based on cost and in your case it
30 is based on lists. That seems to be your practice and



1 we accept it, we just want to understand it, so on cost
2 you have a mark-up of 66 2/3 per cent?

3 MR. MADAY: Yes, the reason why we
4 chose this method is because we do not know what our
5 cost is. I have received a substance from the wholesaler
6 which is layed down to my back door of the store at
7 sixty cents; one hour from there and it is no longer
8 sixty cents. It would be a physical impossibility for me
9 to know how long I keep a medication on the shelf, it
10 might be there two or three months. Every time I dispense
11 a prescription, I have no idea how long I have had it.
12 I cannot use sixty per cent, I have to use on the average
13 a forty per cent mark-up.

14 COMMISSIONER FIRESTONE: You realize
15 you are in a position that all other retailers are because
16 they do not sell their products the moment they put them
17 on the shelves.

18 MR. MADAY: No, we are not.

19 COMMISSIONER FIRESTONE: Could you
20 explain that, then?

21 MR. MADAY: The pharmacist is, I hate
22 to use the word, but he is a different boy. The merchan-
23 dise on his shelves whether it is chloromycetin,
24 alkamycin or chlortipalon, it does not matter. You have
25 all these products. I cannot sell these things until
26 I obtain a prescription from the doctor, therefore, I
27 am not a merchant, I am not merchandising my products.
28 I cannot go out and I cannot say "This thing has been on
29 my shelf for three months, I will get rid of it no matter
30 what it costs me". In other words, I cannot merchandise



1 it, I am a captive buyer and the only man who can tell
2 me what to do with the product is the doctor. I am
3 limited by law as to what I can do.

4 COMMISSIONER FIRESTONE: I think that
5 is reasonable enough. There is a difference in your
6 practice to that of other retailers but the fact remains
7 that the fact of the matter is that you are charging, on
8 the example we have worked out on a one dollar drug, a
9 mark-up of about two-thirds of two-thirds of the cost.

10 MR. MADAY: Yes.

11 COMMISSIONER FIRESTONE: There is no
12 objection to it because you may have very little left
13 after you have kept that drug for a couple of months and
14 your overhead may eat up more than sixty per cent. This
15 is not the point. The point we are driving at is simply
16 this; as drug distributors you are charging, your mark-
17 ups are based on list and cost as we have discussed it.
18 Now, what is the incentive of a drug distributor to
19 purchase the drug at the lowest possible price? Incentive
20 usually is that you would be more competitive but if
21 everyone sells at the same list price then the element
22 of competition does not arise. Further more, since you
23 are getting a fixed mark-up, the higher the price, the
24 higher the list price, and higher the return to the
25 distributor. Where then is the incentive of the
26 pharmacists to get prices down to the lowest possible cost
27 to the patient or to the person purchasing the drug?

28 MR. MADAY: Incentive, of course,
29 lies with the individual himself that he wishes to
30 operate the pharmacy as economically as possible. He is



1 there to provide service and if he is able to skimp and
2 save he can pass on some of the savings to these patients
3 and if he does not do that and ends up with a terrific
4 net profit he will, of course, lose it to the government.

5 COMMISSIONER FIRESTONE: We have no
6 objection to the druggist making as much profit as he
7 can, but the question that we have is, what is the
8 incentive to pharmacists to get the lowest cost to the
9 purchaser of drugs? If I understand your position
10 correctly, it is in your interests to sell the drugs at
11 the list price and if the list price is high then the
12 returns to the druggist will be higher. This is simple
13 arithmetic unless you are prepared to sell below the
14 list price.

15 MR. MADAY: Yes, unless you are
16 prepared to sell.

17 COMMISSIONER FIRESTONE: Let us look
18 at the question of what the druggist can do to bring the
19 cost down below the list price or is he satisfied to sell
20 at the list price?

21 MR. MADAY: He is satisfied to sell at
22 the list price because the average has shown he ends up
23 with a certain amount of money and the net profit being
24 five per cent, he cannot reduce below this, otherwise
25 he is not making the margin of profit which would then
26 remunerate him for the investment of time and investment
27 of capital he has put in.

28 COMMISSIONER FIRESTONE: If I under-
29 stand you correctly there is little incentive to sell
30 below the list price because if you did you would not get



and if he does not do that and ends up with a terrific
net profit he will, of course, lose it to the Government.
COMMISSIONER HILSTON: We have no

objection to the drugist making as much profit as he
can, but the question must be put in, what is the
increase to pharmacists to get the lowest cost for the
purchase of drugs? If I understand your position
correctly, it is in your interests to sell the drugs at
the list price and at the list price to high than the
normal so the drugist will be richer. This is a simple
argument unless you are prepared to sell below the
list price.

MR. HADAY: Yes, unless you are
prepared to sell.

COMMISSIONER HILSTON: Let us look
at the question of what the drugist can do to bring the
cost down below the list price or is he entitled to sell
at the list price?

MR. HADAY: He is entitled to sell at
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with a certain amount of money and the net profit being
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he is not making the margin of profit which would then
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of capital he has put in.

and you correctly there is little incentive to sell



1 a reasonable reward for the labour and the work you put
2 in or the return on your capital investment. Is that the
3 point?

4 MR. MADAY: That is it.

5 COMMISSIONER FIRESTONE: But is there
6 any objection to trying to get the drugs to where
7 perhaps the list price would be lower?

8 MR. MADAY: There is no objection,
9 no, sir.

10 COMMISSIONER FIRESTONE: Are efforts
11 being made --- I am thinking now of trying to replace
12 where possible the use of brand-names by generic names,
13 by a generic type drug?

14 MR. MADAY: But we cannot because
15 it is controlled by the doctor. I cannot go to a doctor
16 where he has specified a certain thing because he may
17 have reasons for it. I cannot go to him and say, "I
18 will give you this."

19 COMMISSIONER FIRESTONE: Let us
20 examine another possibility of bringing down the cost
21 of drugs; have pharmacists in Alberta considered co-
22 operative buying from wholesale establishments in order
23 to buy at a large scale and, therefore, reduce the unit
24 cost. The government of Alberta in its submission
25 yesterday has pointed out to us the substantial price
26 differential that exists between the drugs purchased by
27 hospitals and the drugs purchased by the pharmacists.
28 One of the explanations that was given to us, there was
29 a number of them, but one of them was in one case, the
30 larger quantity and in another case, a smaller quantity.



1 Could the pharmacists not join in a venture of buying
2 in large quantities from a co-operative wholesale
3 arrangement which has been done in the food business, has
4 been done in the other fields, so why not in the field
5 of drugs in the province of Alberta?

6 MR. MADAY: It has been tried. In
7 Edmonton we had the North-West Drug Co-operative, a
8 pharmacist owned co-operative entering into the whole-
9 sale field and, therefore, passing on the savings to the
10 members who were participating in the use of the drugs.

11 COMMISSIONER FIRESTONE: Would the
12 druggist pass on the savings to the persons purchasing
13 the drugs from them?

14 MR. MADAY: The savings were not
15 sufficient and the North-West Drug Co-operative is now
16 the North-West Drug Company Limited. Pharmacists in
17 this city knew that the hospitals enjoy discounts, the
18 giving of free goods, they buy so much and get so much
19 free. Four or five pharmacists got together and went
20 to the company and said, "All right, we will buy five
21 thousand or ten thousand, whatever you say, and how about
22 one thousand free?" The answer was "No." It was not
23 made available to the retailers, it was made available
24 to the hospitals but not to the drug stores.

25 COMMISSIONER FIRESTONE: Why would
26 you say this experiment of wholesale buying was not
27 successful? When you buy larger quantities you should
28 be able to get the drugs at lower prices and if you can
29 get lower prices you can pass them on. If that is a
30 co-operative arrangement the benefit to the participating



been done in the other fields, as well as in the field

of drugs in the province of Alberta

MR. HADLEY: It has been tried, in

Alberta we had the North-West Drug Co-operative, a

pharmacist owned co-operative selling into the whole-

sale field and, therefore, passing on the savings to the

members who were not used to the use of the drug.

Would the

drugs be as good as the ones in the private

the drugs from the

MR. HADLEY: The savings were not

enough and the fact that the co-operative is now

that of a few years ago the people enjoy discounts, the

kind of these people that are so much and get so much

free, and the people are not together and want

in the company and so it is that we will pay five

thousand a year, whereas, whatever you pay, and how much

one thousand three, the answer was "No." It was not

very much, it was not very much, it was made available

to the hospitals and not to the drug stores.

You say this argument of the people buying was not

successful? When you buy larger quantities you should

be able to get the things at lower prices and if you can

get lower prices you can save more. It is a



1 members, if they had sufficient profit, they could pass
2 on the savings to the purchasers. Why is this system
3 not working in the province of Alberta?

4 MR. MADAY: I regret I cannot answer
5 you because I do not know the financial statement of the
6 operating company.

7 COMMISSIONER FIRESTONE: Would it be
8 possible for you to find out for us? We are looking for
9 ways and means which would suggest in our basically
10 private enterprise system the reduced cost of drugs and
11 perhaps master buying is one way of going about it. We
12 do not know, but in order to establish whether it is
13 reasonable we have to go on the experience of people who
14 have tried it and found it is not feasible. Do you think
15 you could get this for us?

16 MR. MADAY: I regret we cannot tell
17 you. This is a company and I think perhaps the
18 Commission could ask for it and you would probably get
19 it much quicker than I can.

20 COMMISSIONER FIRESTONE: Your
21 association is not aware and you have no members of your
22 association that were members of the co-operative and
23 know the story?

24 MR. MADAY: It is no longer a co-
25 operative.

26 COMMISSIONER FIRESTONE: If it was
27 operated presumably some of the members who participated
28 would know why it was a failure.

29 MR. MADAY: May we say it could be
30 private information and I do not know -- I could inquire.



1 COMMISSIONER FIRESTONE: Have you
2 yourselves as people that are in the pharmaceutical
3 business and that are aware of the public complaints
4 about drug prices being so high any concrete suggestions
5 of what can be done to bring them down? I would remind
6 you that we as a Commission have no views whether they
7 are high or low, but you may have some views.

8 MR. MADAY: No, sir, we do not know
9 why the manufacturer places the cost to us where he does
10 place it.

11 COMMISSIONER FIRESTONE: I come to
12 the last point. The province of Alberta in its
13 submission yesterday suggested that one way of dealing
14 with the high cost of drugs would be to set up a federal
15 agency. I believe you were sitting in on the discussions
16 and you are familiar with the outline of the terms of
17 reference of this federal agency. I can quote it to you
18 if you wish but if you are familiar with it --- are you
19 familiar with it?

20 MR. MADAY: Would you quote it again?

21 COMMISSIONER FIRESTONE: I will be
22 glad to. This is a quotation from the brief of the
23 Alberta government, paragraph 379 at page 115, sub-
24 paragraph 4:

25 "(4) that with a view to combating the
26 high cost of drugs, the Commission should recommend the
27 setting up of a federal agency with power and direction -
28 (1) to examine the revenue-cost posi-
29 tion of individual drugs so as to
30 determine the costs as well as profits



1 of manufacturing and marketing;

2 (ii) to serve as a source of informa-
3 tion for physicians, pharmacists, hospi-
4 tals and others concerning new drugs,
5 modifications and combinations, so as to
6 eliminate or moderate the present cost
7 to manufacturers of bringing such drugs
8 to the attention of the people concerned;

9 (iii) to encourage, in the interest of
10 price savings, the widest use of quality
11 generic drugs by physicians and retail
12 pharmacists.

13 (iv) to assure that The Patent Act,
14 The Food and Drugs Act or any other
15 legislation does not stand in the way
16 of any steps which might be taken to
17 reduce the cost of drugs.

at any and sundry:

(1) to serve as a source of information

(2) to be employed in the interest of

persons known by the agents and informants

(3) to conduct the business of

the person or persons who are

interested in the same in any way

or for any other purpose

or for any other purpose



1 Now, my question is this: Does the
2 Alberta Pharmaceutical Association support this proposal?

3 MR. MADAY: I would say not in total
4 but we would have to study it to give you a true answer
5 on that.

6 COMMISSIONER FIRESTONE: We will,
7 therefore, expect that you will consider this and advise
8 us in writing at a subsequent time?

9 MR. MADAY: We can do that, yes, sir.

10 COMMISSIONER FIRESTONE: Thank you
11 very much.

12 THE CHAIRMAN: Thank you very much, Mr.
13 Maday and gentlemen for this presentation and for the
14 information that you have given us. Before you leave,
15 do any one of the four of you have any statements to make
16 or any information to volunteer arising out of the
17 discussion?

18 MR. CAMERON: Mr. Chairman, I think
19 it should be entered into the record on behalf of the
20 association that we again take this opportunity of asking
21 the federal government to remove the sales tax. This
22 in itself would affect an immediate savings.

23 THE CHAIRMAN: How much?

24 MR. CAMERON: Eleven per cent.

25 THE CHAIRMAN: Where is it applied?
26 It is not on the retail price?

27 MR. CAMERON: No, the manufacturer's
28 level.

29 THE CHAIRMAN: So that I know this is
30 being put forward, but if you are putting it seriously,



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MR. MADAY: We can do that, yes, sir.

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1 have you given consideration to either factors, that the
2 great increase is between the manufacturer's level where
3 the sales tax is imposed and the price to the retail
4 druggist which is the basis of the cost to the consumer.

5 MR. CAMERON: But if we are examining
6 all means of reducing the price this is surely one.

7 MR. MADAY: It is a factor. If this
8 ends up to be small, it is still a factor. It appears
9 our government is willing to take it off all other items
10 which are not essential and they leave it on drugs.

11 THE CHAIRMAN: On all drugs?

12 MR. MADAY: Not all drugs, but there
13 are very few exceptions.

14 THE CHAIRMAN: Anything else, Mr.
15 Cameron?

16 MR. CAMERON: I think not, Mr. Chair-
17 man.

18 THE CHAIRMAN: Thank you very much
19 again, gentlemen.

20 MR. MADAY: Thank you very much for
21 allowing us to present this brief.

22 THE CHAIRMAN: The next item is the
23 submission of the Chaplaincy Advisory Committee of the
24 Calgary General Hospital.

25 THE SECRETARY: This will be known
26 as Exhibit 118.

27
28 EXHIBIT NO. 118: Submission of the
29 Chaplaincy Advisory
30 Committee of the Calgary
General Hospital.



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13 are very few exceptions.

14 THE CHAIRMAN: Anything else, Mr.

15 Cameron?

16 MR. CAMERON: I think not, Mr. Chairman.

17 MR. MADAY:

18

19

20 MR. MADAY: Thank you very much for

21 allowing us to present this brief.

22 THE CHAIRMAN: The next item is the

23 submission of the Oshawa Advisory Committee of the

24 Oshawa General Hospital.

25 THE SECRETARY: This will be known

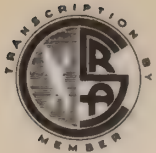
26 as Exhibit 118.

27

28

29 Committee of the Oshawa

30 General Hospital.



SUBMISSION

of

THE CHAPLAINCY ADVISORY COMMITTEE

of the

THE CALGARY GENERAL HOSPITAL

APPEARANCES:

CHAPLAIN STANLEY HUNT, Chairman of the
Committee

CHAPLAIN WILLIAM BATES, Secretary.

CHAPLAIN HUNT: Mr. Chairman, it is
our pleasure to introduce ourselves to you and to your
Commission, the speaker, Stanley Hunt, Chairman of the
Chaplaincy Advisory Committee of the Calgary General
Hospital, and my colleague, Chaplain William Bates,
Secretary of that Committee.

We wish to state that we appear with
the full support of the committee as it is listed on
page 3 of the brief and that gives us a great deal of
confidence and a great deal of pleasure. Our work is
widely based. Mr. Bates is a member of the Anglican
Church and has had the endorsement of the clergy of his
diocese and the presbytery of the United Church of
Canada has also given attention to the brief and has
commended it.

We feel also that we have the full
co-operation of the staff of the General Hospital in
Calgary. There are some times difficulties that arise



SUBMISSION

of

THE CHAPLAINCY ADVISORY COMMITTEE

of the

THE CALGARY GENERAL HOSPITAL

APPENDIX

CHAPLAIN STANLEY HUNT, Chairman of the

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1 with visitors, and we have sought to exercise a very,
2 very mild disciplinary function as complaints have been
3 made to us of religious visitors within the hospitals.

4 SUMMARY OF BRIEF

5 I. Modern medical science, alone, cannot meet the
6 patient's total need of "wholeness" or health;
7 he must have access to healing services and
8 aids for his mind and spirit for the well-
9 being of his "self".

10 II. The hospital, under present-day conditions,
11 can best supply this through an appointed Staff
12 Chaplain, available, integrated into the heal-
13 ing team, offering the spiritual resources
14 desired by the patient.

15 If I might take your time, I would like
16 to say neither Chaplain Bates nor myself classify our-
17 selves as experts or potential staff chaplains. We are
18 demominational chaplains appointed and supported by our
19 own churches.

20 After a little less than two years
21 experience in our work, it is our considered judgment
22 we find definite limitations to our functioning. We are
23 pleased with the work we are able to do. We feel not
24 adequate according to the need of the patient at the
25 present time and, therefore, we make the following
26 recommendation. That is one page 5:

27 1. That the Government of Canada be asked to
28 enlarge financial contributions to Provinces
29 under Chapter 28 (1957) of the Hospital
30 Insurance and Diagnostic Services Act for

with visitors, and we have sought to exercise a very, very mild disciplinary function as complaints have been made to us of religious visitors within the hospitals.

I. Modern medical science, alone, cannot meet the patient's total need of "wholeness" or health; he must have access to healing services and aids for his mind and spirit for the well-being of his "body".

II. The hospital, under present-day conditions, cannot supply this through an appointed staff chaplain, available, integrated into the healing team, offering the spiritual resources

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I. That the Government of Canada be asked to



1 the provision of chaplains and chaplains'
2 services in hospitals as an extension of
3 in-patient services on the grounds of the
4 main points listed on page 4: 1, 2, 3, 4,
5 5, and 6.

6 Shall I run through these points or
7 are they quite well known to the Commission?

8 THE CHAIRMAN: We will leave it to
9 you if you wish to summarize or just bring them forward
10 in your own language.

11 CHAPLAIN HUNT: Yes. Main point one
12 on page 4.

13 1. Psychosomatic Medicine is concerned with the
14 need of the patient as "psyche" - soul, mind
15 and spirit as well as "soma" - body (physical).

16 These may be found on Appendix A,
17 page 3, in which the needs of the patient are drawn out.
18 I beg your pardon, on page 1, objectives of a chaplaincy
19 programme.

20 One of the founders of the modern
21 hospital chaplaincy movement, Russell L. Dicks, said
22 that there are seven major conditions of the sickroom
23 which may it imperative that religious ministry be made
24 available to those patients who desire it. These
25 conditions are pain, anxiety, hostility, guilt feelings,
26 boredom, despair and loneliness. This enumerates the
27 needs of the patient for which we feel, as we state,
28 an on staff chaplain is required.

29 2. To heal the body and leave the soul, mind
30 and spirit disordered, if this disorder has



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needs of the patient for which we feel, as we state,
an on staff chaplain is required.

2. To heal the body and leave the soul, mind
and spirit disordered, if this disorder has



1 occasioned the physical disability, is an
2 incomplete health service.

3 3. Modern conditions of mobility of people and
4 pressure upon local clergy leave the patient
5 often without the available spiritual resource.

6 We enlarge upon that in the body of
7 the brief. I have known personally within the last two
8 years two people after a period of hospitalization and
9 having no callers except those who gave them their
10 medication or examination who have regularly returned
11 for months and months following their release from
12 hospital to give friendly calls to people who wouldn't
13 have other callers.

14 In the terrific drive of the pace of
15 life today, in our large impersonal hospitals;
16 we are amazed that there are people who are so lonely
17 and feel uncared for. We find doctors some times saying
18 this man, this patient is improving, but it doesn't
19 feel any better. They are at their wits ends sometimes
20 because the patient has not, without ministry of the
21 whole self; has not achieved the high sense of dignity
22 and of his wholeness of being.

23 4. This indicates the necessity of the healing
24 team within the hospital offering this resource
25 to those desiring it.

26 We are happy to say in our experience
27 in the General Hospital in Calgary we are asked to
28 provide and we are doing a fruitful sort of service that
29 otherwise wouldn't be done.

30 5. The organization for this spiritual service



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in the General Hospital in Calgary we are asked to

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otherwise wouldn't be done.

5. The organization for this spiritual service



1 has been worked out in some institutions,
2 (e.g. in hospitals administered by the
3 Department of Veterans Affairs.)

4 THE CHAIRMAN: Would you expand
5 that a little more? What do you mean? How is it worked
6 out in the Veterans Affairs?

7 CHAPLAIN HUNT: The chaplain is
8 appointed, I suppose, with the understanding he is
9 appointed as a all-protestant chaplain. He is given his
10 office and his work is within the hospital, and he has
11 conduct of any services that may be held in the nature
12 of protestant services.

13 It seems a very happy arrangement. I
14 haven't known of any experience in which the chaplain
15 service has been withdrawn from a Veterans Hospital.

16 THE CHAIRMAN: For the other faiths
17 there would be some other?

18 CHAPLAIN HUNT: Yes, I think with
19 the Roman Catholics the nearest parish priest is the
20 chaplain for that hospital, and other clergymen, of
21 course, are welcome to come in, but this is the over-all
22 pattern of procedure.

23 Padre Orme of Polsher Hospital has an
24 office of his own. He lets it be used by any clergyman.
25 He is a protestant chaplain. He is there full-time,
26 conducts all worship services and is on call every day.
27 The hospital can send him anywhere. I hope this can
28 lead to others in the ministry.

29 6. The cost can be met following the precedent
30 of the National Hospitalization Plan.



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1 I would like to say the staff chaplain
2 is not to minimize in any way the opportunity and the
3 work and service of any local clergyman, rather, a
4 clearing house for a ~~great number of~~ clergymen. He
5 would do over-all coverage. We feel so there would be
6 no gaps. So many people are not known in the cities to
7 any congregation. We find at the congregation level
8 or priest level, people are not known even then.
9 They have been there, two, three, four years and they
10 have never introduced themselves to any of the
11 congregation or to the pastor, and when the pastor looks
12 over the list, he doesn't recognize them as his people.

13 We feel that the health and well-
14 being and treatment of the patient suffers in this
15 respect.

16 THE CHAIRMAN: Thank you, Mr. Hunt.
17 Do you wish to add something, Mr. Bates?

18 CHAPLAIN BATES: I would like to
19 say one thing, sir, Mr. Chairman, that the association
20 between religion and medicine is really a long one.
21 Even in Plato's day, Plato had to point that the man,
22 that the patient, you and I, are more than merely a body.
23 He says:

24 "This is the greatest mistake in the
25 treatment of disease, that there are doctors
26 for the body and doctors for the soul, when
27 neither one can be separated from the other.
28 But this is precisely what Greek doctors
29 overlook, and that is why so many diseases
30 escape them. In short, they never see the



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1 whole. But it is the whole which should
2 command their attention, for if the whole
3 is sick, it is impossible for any of the
4 parts to be healthy."

5 We have been finding increasingly that
6 our contribution is welcome. I think the doctor
7 realizes the value of what he is doing. What is happen-
8 ing now in the States and on the Continent is a kind of
9 pastoral, clinical, pastoral training movement. This
10 has happened over the last three decades. It has quite
11 largely developed in the States. I think it is included
12 in our appendix of the Model Guide that is the fruit of
13 these three decades, of a lot of thought, a lot of
14 experiments and work and it indicates that their feeling is
15 that this is really worthwhile.

16 I think that the chaplains' contribu-
17 tion is desired by the doctor and it is a sense in which
18 the church has been a bit slow." The church has to have
19 the willingness to take training to get into the position
20 of it, in the terms of counselling and the various ways
21 to bring the resources of our faith to bear.

22 I think now the doctor has come around
23 to see the man as the whole man, and in a sense, I think
24 today the profession of medicine is actually ahead of
25 the church. I don't want to be quoted like this. There
26 is a sense in which we are invited to make our
27 contribution as we can. We will have to accept training.

28 There is one other thing, Mr. Chairman,
29 Professor Adolf Koberle, who lectures in Systematic
30 Theology at the University of Tuebingen is quoted in



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1 Universitas -- a German Review of the Arts and Sciences
2 ---Quarterly English language edition --- Volume 3,
3 No. 2 --- 1959/60, page 147, artucke -- Doctor and
4 Clergyman in the service of Modern Man. (page 153) ---

5 "What we are today, both doctors and
6 priests (clergy), once again trying to
7 consider man as a whole, is one of the
8 hopeful signs of our age. The ideal would
9 be to have doctors who are at home in Xn
10 Theology and xina care for the soul, and
11 theologians able to train as doctors..
12 That this dual study is, except in rare
13 cases, hindered by economic considerations
14 and intellectual aptitudes, means that we
15 are left with but one possibility. Joint
16 societies for doctors and theologians
17 should be created in order to regain the
18 long lost synthesis."

19 I point out in our brief we include
20 at the appendix at the end a letter from Professor Carl
21 Jung who suggests more completely the modern problem
22 when he brings religious resources together with
23 psychological knowledge and insight. A PSYCHOLOGICALLY
24 orientated clergy can be of great value in the hospital
25 setting.

26 I think that yesterday we had a
27 presentation of a brief from the Academy of Religion and
28 Mental Health. This is their letter. They are working
29 on the bringing together a disciplinary approach to
30 man's problem in society.



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That this ideal may be, except in rare

cases, is a fact which we must face.

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1 It seems to me the hospital provides
2 the ideal setting for a conscious bringing together of
3 the various disciplines and the problem is one man must
4 have it himself, all of the things in order to meet
5 these things, all these different roles of the patient.

6 Thank you very much.

7 THE CHAIRMAN: Thank you, gentlemen.
8 Your recommendation on page 5, the government of Canada
9 be asked to enlarge financial contributions to the
10 province for the provision of chaplains and chaplains'
11 services in hospitals as an extension of in-patient
12 services. What is the situation in Alberta with regard
13 to the recognition by the province of chaplain services
14 as a cost, as an item of cost for which the hospital is
15 paid by the province? Do you know?

16 CHAPLAIN BATES: I think the Calgary
17 General Hospital is moving toward the day of having a
18 chaplain service, the development of a full chaplaincy
19 service. I believe the administration and increasing
20 medical staff desire this, but there is a need to provide
21 finances for this. We have a chapel. We have a
22 chaplain's office. We have a family room for counselling
23 and for families so that the hospital has itself moved
24 as far as it can.

25 THE CHAIRMAN: Now, this matter -----

26 CHAPLAIN BATES: I haven't answered
27 your question yet.

28 THE CHAIRMAN: I am going to expand
29 it. I may put it this way, that before the Dominion
30 government, the federal government contributes to the



HUNT

the ideal setting for a conscious bringing together of the various disciplines and the problem is one man must have it himself, all of the things in order to meet these things, all these different roles of the patient. Thank you very much.

Your recommendation on page 5, the Government of Canada is asked to enlarge financial contributions to the province for the provision of chaplains and chaplains' services in hospitals as an extension of inpatient services. What is the situation in Alberta with regard to the recognition by the province of chaplain services as a cost, as an item of cost for which the hospital is paid by the province? Do you know?

CHAIRMAN: I think the Calgary General Hospital is moving toward the day of having a chaplain service, the development of a full chaplaincy service. I believe the administration and increasing medical staff desire that, but there is a need to provide financing for that. We have a chapel. We have a chaplain's office. We have a family room for counselling.

as far as it goes.

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Your question yet.

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1. I may put it this way, that before the Dominion Government, the federal government contributes to the



1 operative costs of hospitals in a province, that cost
2 must be recognized by the provincial authority initially
3 and go into the amount for which fifty per cent is claimed
4 from the federal government.

5 Where do we stand in Alberta as to
6 where is this cost going into the figure for which you
7 can ask the federal government to contribute fifty per
8 cent?

9 CHAPLAIN BATES: Perhaps Mr. Hunt
10 could answer that.

11 CHAPLAIN HUNT: I don't think it
12 has been clearly faced. We were breaking new ground in
13 submitting this brief, and making this request. We
14 don't know if it has been presented anywhere else.

15 THE CHAIRMAN: No, it is new so far
16 as the Commission is concerned in this respect.

17 CHAPLAIN HUNT: As we began to
18 examine the basis of such a request, we found right at
19 our elbow the hospital administration, of course, within
20 the province was administered by the Dominion government
21 under the Department of Veteran Affairs. That is our
22 jurisdiction for this recommendation.

23 We do not know of any chaplain service
24 or any religious service that had been assessed in any
25 other instance.

26 CHAPLAIN BATES: In addition,
27 notice that part of our committee has an administrator
28 on it, so we do not know his thinking as well as he does.

29 THE CHAIRMAN: Have you gone this
30 far, to put your proposal --- I mean, your basic



operative costs of hospitals in a province, that cost
must be recognized by the provincial authority initially

from the federal government.

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where is this cost going into the figures for which you
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THE CHAIRMAN: Have you gone into

to put your proposal --- I mean, your case



1 proposal -- to the provincial government, because you
2 have got to get in the provincial budget before you can
3 go on to Ottawa. That is perhaps putting it rather
4 awkwardly.

5 CHAPLAIN HUNT: We welcome that
6 request. We have not made the request of the provincial
7 government. The provincial government has not had a
8 Commission on Health Services.

9 THE CHAIRMAN: It is the Minister
10 of Health who controls under the Act?

11 CHAPLAIN HUNT: We would be very
12 glad to confer with him.

13 THE CHAIRMAN: I mean, I am not
14 suggesting or trying to give you direction, but ----

15 CHAPLAIN HUNT: We have not done so
16 because we have not -- we just have not explored that
17 far.

18 THE CHAIRMAN: Well, it has been
19 suggested to me that there is some reluctance in the
20 Department of Health to provide; to recognize the
21 construction of, say, chapels in voluntary hospitals as
22 part of the cost for which the province will contribute
23 or pay, and I assume you have no knowledge of that phase
24 of it?

25 CHAPLAIN HUNT: No, no.

26 THE CHAIRMAN: But there would appear
27 to be hurdles to be overcome?

28 CHAPLAIN HUNT: We do appreciate the
29 financial problems that our hospital boards have to face:
30 Where to find the money for these services that are



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to as much as to be overcome?
 CHAIRMAN: We do appreciate the
 financial problem that our hospital boards have to face
 Where to find the money for these services that are



1 deemed essential. Just speaking for the cause, I suppose
2 the provincial Department of Health have an awareness
3 of the financial disabilities also.

4 THE CHAIRMAN: They told us yesterday
5 they fixed a maximum figure within which a hospital must
6 operate, and if they want to provide extra services,
7 such as a chaplaincy service, I suppose they are perfectly
8 free to do it as long as they pick up the tab for it
9 themselves.

10 CHAPLAIN HUNT: Yes.

11 THE CHAIRMAN: Now, all I am asking
12 now is whether in the light of that situation you consider
13 that you ought not to start at the provincial level. If
14 you do, and achieve anything, we would be very happy to
15 hear from you with any further results that you may
16 obtain in the next short while while the Commission is
17 still in being, and before it makes its final report.

18 CHAPLAIN HUNT: Yes. Thank you, Mr.
19 Chairman. The Commission may understand that this is
20 an education to us. On the basis of our own work, when
21 we started, we found it was the need of the people --
22 the need of the people was present before us in ways
23 that are not being sufficiently intelligently grappled
24 with, and so that is the reason we have stated in the
25 first paragraph of the brief on page 6 the purpose to
26 submit the need of the patient challenges the health
27 services of the hospital to include the chaplain as a
28 necessary member is its healing team. That is our main
29 concern, and we know that we must get down to earth and
30 make the necessary contacts about finances. This is the



1 driving force that is behind us.

2 THE CHAIRMAN: I think we could say
3 to you that the philosophical concept, the approach,
4 must meet corresponding response from, I think, all
5 members of this Commission, and from the general public
6 as such.

7 Now, what you have said we will remember
8 and give consideration to, but if you go ahead your-
9 selves along the road in the meantime while we are still
10 functioning, we would be pleased to hear from you and
11 to know what you have accomplished.

12 CHAPLAIN HUNT: Thank you, Mr. Chair-
13 man, and we hope we may be able to communicate with you
14 with the desired results.

15 THE CHAIRMAN: Thank you very much.

16 CHAPLAIN HUNT: Or with the desired
17 information.

18 THE CHAIRMAN: Or the desired results.

19 CHAPLAIN HUNT: Thank you.

20 THE CHAIRMAN: We will now recess
21 until nine o'clock tomorrow morning when we will proceed
22 with the submission of the Alberta Dental Association.

23

24 --- Adjournment.

25

26

27

28

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30

